VA HEALTH CARE DELIVERY IN THE WESTERN REGION

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

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CONTENTS

NOVEMBER 22, 1983

	Page
VA Health Care Delivery in the Western Region	1

OPENING STATEMENTS

Chairman Bob Edgar	1
Hon. John Paul Hammerschmidt	4
Hon. Barbara Boxer	6

WITNESSES

Battisti, Paul, administrator, the Veterans Home of California, and representing the Department of Veterans Affairs, State of California	35
Prepared statement of Mr. Battisti	112
Blakey, Louis G., Unified Arizona Veterans	13
Prepared statement of Mr. Blakey	77
Brady, Jack E., national junior vice commander, American Ex-Prisoners of War	20
Prepared statement of Mr. Brady	91
Cooney, Daniel E., Director, Western Medical Region, Veterans Administration	40
Prepared statement of Mr. Cooney	114
Countryman, Richard, Director, Arizona Veterans Service Commission	12
Prepared statement of Mr. Countryman	66
DeNiro, Jim, Director, VA Medical Center, Palo Alto, Calif	44
Foye, Dr. Lawrence V., Jr., Director, VA Medical Center, San Francisco, Calif	44
Goldman, Hal, commander, Department of California, the American Legion	30
Prepared statement of Mr. Goldman	108
Gunnels, Earl, Jr., commander, Department of California, Veterans of Foreign Wars	29
Prepared statement of Mr. Gunnels	104
Kruse, Arthur P., executive director, Department of California, AMVETS	24
Mason Joseph J., Director, VA Medical Center, Fresno, Calif	41
Miller, Dr. Michael, Assistant Regional Manager, readjustment counseling program, Western Region, Veterans Administration	49
Nixon, Clarence H., Director, VA Medical Center, Martinez, Calif	43
O'Rear, Marvin E., Director, VA Medical Center, Livermore, Calif	40
Prepared statement of Mr. O'Rear	125
Pittelkow, Edward F., president, Bay Area and Western Chapter, Paralyzed Veterans of America	24
Prepared statement of Mr. Pittelkow	98
Potter, Harry C., Director, VA Medical Center, Reno, Nev	43
Reed, Nancy, occupational therapist, VA Medical Center, Palo Alto, Calif	6
Routt, Melvin L., national director, AMVETS	23
Prepared statement of Mr. Routt	96
Ruppenthal, James T., national service officer, Disabled American Veterans	31

Material Submitted for the Record

Statements: Page
DeConcini, Hon. Dennis, a U.S. Senator from the State of Arizona 53
McNulty, Hon. James F., Jr., a Representative in Congress from the State of Arizona 57
Shumway, Hon. Norman D., a Representative in Congress from the State of California 128
Written committee questions and their response:
Hon. John Paul Hammerschmidt to VA 128
Hon. Norman D. Shumway to VA 127

VA HEALTH CARE DELIVERY IN THE WESTERN REGION

TUESDAY, NOVEMBER 22, 1983

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The subcommittee met, pursuant to notice, at 2:30 p.m. in the Ceremonial Courtroom, U.S. Courthouse and Federal Building, 450 Golden Gate Avenue, San Francisco, Calif., Hon. Bob Edgar, chairman, presiding.

Present: Representatives Edgar, Mica, Penny, Evans, Hammerschmidt, and Kaptur.

OPENING STATEMENT OF CHAIRMAN EDGAR

Mr. EDGAR. The Subcommittee on Hospitals and Health Care will come to order.

On behalf of the subcommittee, I wish to welcome each of you to this oversight hearing on VA's health care delivery facilities in the VA's Western Medical Region.

This is the last of six field hearings that we've held across the country. We've been to western Pennsylvania, to Chicago, to Boston, to Florida, and to Denver, Colo. We've been to many areas of the country looking at old hospitals and new hospitals. We've looked at Vietnam veterans' treatment programs in storefront centers and inpatient programs.

We've been concerned about the issue of aging veterans and women veterans and atomic veterans. We've looked at the veterans hospital system and the many outreach clinics and storefront centers and we've tried to analyze what the future of that health care system is going to be over the next 5 and 10 years.

With me here in San Francisco are a very large number of Members of Congress who serve on the House Veterans' Affairs Committee and on its subcommittee dealing with hospitals and health care.

I want to first thank them for their attentiveness in visiting the area hospitals in Palo Alto, in Livermore, the Navy hospital, as well as the San Francisco Veterans' Hospital today.

I want to thank them for their commitment over the last several months as they've gone across the country to do this mission, and I want to thank each of you in the audience for coming to participate today. The hearing should not be too scary.

We're going to go through a series of witnesses and panels and we're going to try to hear from as many people as we can on a variety of issues. We will have questions from the Members of Congress who are here and we hope to conclude this hearing in approximately 2 hours. We hope that all of the people who testify will bear with us and give us their frank impressions and ideas, answer our questions, and help us to focus on this important issue.

I'm going to read an opening statement. I will then introduce the Members that are with me today and then I will call on these Members for their opening statements, and then we will begin.

Yesterday, we toured the VA Medical Center at Palo Alto and the one at Livermore. The VA Medical Center at Palo Alto has two major construction projects ongoing: A center core building at the Menlo Park division scheduled for completion in December 1984 at a cost of over $16 million; and a surgical addition and correction of fire and safety deficiencies project scheduled for completion in November 1985 at a cost of over $14 million.

We also toured the Naval Regional Medical Center in Oakland yesterday afternoon. This morning we were at the San Francisco VA Medical Center where a major facility improvement construction project is underway at a cost of over $33 million. This project is scheduled for completion in August of 1986.

This series of oversight hearings is particularly important at this time due to the crossroads that the VA health care delivery system faces over the next 5 to 6 years in providing quality and quantity medical services to eligible veterans.

In the six VA medical centers in Medical District 27 of this medical region, there has been allocated in the current fiscal year some $305 million and 7,000 employees to provide health care to eligible veterans.

In fiscal year 1983, Medical District 27 served 892,000 veterans. By 1990, it is estimated that this figure will increase to over 1 million veterans. However, over the same period the number of veterans 65 and older will increase to 344,000 veterans. It's an increase of 25 percent of that population.

Nationwide, the VA has estimated the demand placed on the medical system due to increasing numbers of aging veterans will triple in the next 10 years. By 1990 alone, more than one-half of all American men over the age of 65 will be veterans. Right now, due to unemployment, more and more veterans are coming to the VA for the first time.

These facts indicate that we not only have a present problem but a future problem in maintaining the quality and quantity of care. The rapidly advancing age of veterans not only places a heavy demand on the VA for nursing home care, but also for hospital care resulting from acute episodes of chronic illness in older veterans. We must cope with this present demand, but most important we must be prepared to accommodate the future demand on the system as well.

We must also be alert to respond to the unique and changing needs of many other segments of the veteran population. For instance, we must address the continuing serious readjustment problems faced by thousands of Vietnam era veterans. H.R. 2920, as amended, extends the veterans readjustment counseling program

until 1988, 4 additional years, and calls for a study of the veterans with service-connected disabilities and with specific reference to women veterans on the problems and incidents of post-traumatic stress disorder and other psychological problems in readjusting to civilian life among veterans who served in the Vietnam theater of operations and the effects of such problems on these veterans. I might share with you that this legislation was signed by the President into law yesterday, so it guarantees the 4-year extension of the Readjustment Counseling Centers

Yet another example is meeting the medical needs of those veterans deeply concerned about the effects of exposure to the defoliant, agent orange. Likewise, we must provide medical assistance to those concerned veterans who were exposed to nuclear radiation during atmospheric atomic testing.

H.R. 1961 was ordered reported to the House of Representatives by our Committee on Veterans' Affairs on November 3 of this year. This legislation, if enacted into law, would provide disability and death allowance to veterans and survivors of veterans who served in Southeast Asia during the Vietnam era and suffer within 20 years from the time of departure from Vietnam from soft tissue sarcomas or who, within 1 year from the time of departure suffer from porphyria cutanea tarda, a liver disorder, or from a skin condition called chloracne.

Disability or death allowances are also provided veterans and survivors of veterans who participated in atomic tests or the occupation of Hiroshima and Nagasaki and suffer from leukemia, plocythemia vera, a bone marrow disease, or carcinoma of the thyroid within 20 years from exposure to radiation.

The House Committee on Veterans' Affairs is, in my view, the most bipartisan committee in the U.S. Congress.

However, we cannot operate without the cooperation of veterans service organizations and individual veterans. The VA's health care and other benefit programs have been enacted by the Congress as the will of a grateful Nation for the sacrifices these veterans made in serving in the Armed Forces of the Nation.

But apart from that, the American people as a whole have greatly benefited from the investment in VA services and facilities. The VA medical budget for 1984 is approximately $8.1 billion. However, that figure represents only 2.5 percent of all the national health care expenditures.

At the same time, the VA has provided part of the training through its affiliations with the private medical community for more than one-half of all the health care professionals in the United States.

Researchers have already received two Nobel Prizes in medicine. The medical research program has been responsible for finding a cure for tuberculosis, developing the cardiac pacemaker, as well as major breakthroughs in kidney transplants, cancer research, renal disease, hypertension and psychiatry, to name only a few.

Five of the six VA centers in Medical District 27 have active research programs and were allocated over $12 million in fiscal 1984 for VA funded research. The VA is the Nation's largest health care provider with 172 strategically located hospitals and 226 outpatient clinics serving as a primary backup to the Department of Defense

medical system in time of war or national emergency. The investment made in the VA is more than returned in kind.

I would now like to mention the fact that we have with us here Jo Cuney. Jo is on the staff of Senator Cranston. Jo, would you raise your hand.

And I just want to pay special tribute to Senator Cranston for his service in the Senate of the United States on behalf of veterans. He's done an excellent job as previous chairman of that committee and now as the ranking minority member.

Also Senator Dennis DeConcini and Congressman Jim McNulty of Arizona are very concerned about the health care needs of veterans in their State. They were unable to join us this afternoon, but have submitted statements for inclusion in the hearing record. I would ask unanimous consent that their statements be included in the record at this point.

Without objection, that will be so ordered.[1]

I would also like to introduce the members of our committee who are here. Let me start with the Democratic members and then yield to my colleague from Arkansas for his opening statement.

To my left is the Hon. Dan Mica from Florida, an active member of the House Veterans' Affairs Committee.

To his left is the Hon. Lane Evans from the great State of Illinois. Lane is not feeling real well, and we appreciate the fact that he was able to join us this afternoon.

Congresswoman Marcy Kaptur, a freshman Member of Congress and an active member of our subcommittee, is here from the great State of Ohio.

And on the end we have Congressman Tim Penny. Congressman Tim Penny is also a freshman Member from Minnesota. He is a very active member of the House Veterans' Affairs Committee.

I might also point out that it was Congressman Lane Evans' bill that passed that extended the storefront counseling centers for Vietnam veterans.

We also have with us the Honorable Barbara Boxer from the great State of California. While Barbara is not on our House Veterans' Affairs Committee, she has testified before our committee on the issue of agent orange and compensation for those veterans who were exposed to that particular defoliant. We will hear from her in a moment.

Now, it gives me great pleasure to introduce to all of you the Honorable John Paul Hammerschmidt who is the ranking Republican on the House Veterans' Affairs Committee as well as the ranking Republican on this Subcommittee on Health Care.

OPENING STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARKANSAS

Mr. HAMMERSCHMIDT. Thank you, Mr, Chairman.

I want to join our distinguished Chairman in welcoming all of you and saying how delighted we are to be in the bay area, how delighted we are to be with our colleague and friend, Barbara

[1] See pp. 53 and 57.

Boxer, who has testified eloquently, forcefully and articulately before our committee, and to say that we've worked a long time with Senator Cranston when he was chairman and now ranking minority member over there on the Senate Veterans' Affairs Committee. We have a very close and warm working relationship with him.

Mr. Chairman, we have many witnesses, so I'm not going to take much time. I will make a brief opening statement. But I think that your opening statement was so comprehensive, and in your usual capable way, you pretty well expressed to the people here today what's on our mind as it pertains to veterans' affairs.

To repeat a little bit of what the chairman said, over the past year, this subcommittee has conducted five field hearings. We now come to California for the sixth and final session. Actually these are more than hearings. They are combined with visits to VA medical centers and other facilities. They are designed to enable us to learn firsthand how the VA medical program is working, what its field problems are, and how it can be improved.

In my opinion, the endeavor has been a most successful one, Mr. Chairman. I congratulate you on the great leadership in planning it. All of us are now going to be better informed about VA medicine and better able to perform our legislative duties.

Mr. Chairman, the medical program of the VA's Department of Medicine and Surgery is the most comprehensive such program in the world. It is a vast network of hospitals, outpatient clinics, domiciliaries, and readjustment centers. We can't very well visit each of the VA medical facilities. However, by coming to a place like San Francisco, we can get a good picture of it that is most informative.

In this medical district alone, there are six VA hospitals, five outpatient clinics, and eight readjustment centers. The district serves a large veteran population with just about every kind of medical specialty. It is truly a cross-section of the total VA system just as has been the other five places where the subcommittee has visited during the past year.

Mr. Chairman, you have outlined the perimeters of our 3-day visit to this area. You've also made reference to several basic medical issues facing the veterans of our Nation. Issues such as these must command our attention now if we are to adequately prepare for the future. That future even now is almost upon us.

Mr. Chairman, our witnesses today are each very knowledgeable about VA medical care. It has been my privilege to know several of the people from VA. Dr. Larry Foye, the Director at San Francisco, is an old friend who was Deputy Chief Medical Director in VA's Central Office in Washington. Dan Cooney, the Regional Director of this entire medical region, earned an excellent reputation as Director of the VA hospital in Minneapolis, Minn. And Joe Mason came here after being Director at Philadelphia, Wadsworth, and Tuscaloosa. They and the other VA witnesses can tell it like it is, and I am anxious to hear them.

I notice that we have them scheduled last on the program because we like for them to hear the other witnesses. I know that's the reason that you have that format.

But in a similar vein, the representatives of the veteran organizations are always helpful to us, always have good suggestions on

how to improve the VA services and we certainly welcome them, because I don't think we could run our committee in Washington if we didn't have the advice of the veterans service organizations.

Thank you, Mr. Chairman.

Mr. EDGAR. Thank you, John Paul. And I'd like now to call on Barbara Boxer, who is our host Congresswoman from the area, to give a brief opening statement.

OPENING STATEMENT OF HON. BARBARA BOXER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mrs. BOXER. Thank you very much, Mr. Chairman.

I want to thank my colleagues for their graciousness and for inviting me to be here today, though for a brief time, and for including me in your schedule. You have welcomed me before your committee and of that I am most appreciative because we can't serve on every committee we would like to. Sometimes we care very much about an issue, and it is because we have this committee system, and it is so open, that we have the opportunity to make our case.

I just want to take this moment to welcome you to the San Francisco bay area, to tell you how pleased we all are to have you here and to tell the people out there, some of whom are my constituents, what an exceptional committee this really is. They are very dedicated and devoted to the cause of veterans, whether we're talking about aging veterans, Vietnam veterans, women veterans, atomic veterans, or disabled veterans. They care about veterans, and they do serve as your advocates in the House of Representatives.

And it's tough times because it's tough to be an advocate in these days of shrinking dollars. But they carry your cause very, very well. So I am just really here to say that I am proud and pleased to have you here among us, Mr. Chairman and to the distinguished minority member. We will do our best to see that you do learn just what you need to learn so that you can get back there and fight for us as you've been doing all these years.

Thank you very much.

Mr. EDGAR. I appreciate that. It's not often that six Members of Congress gather in one place outside of the city of Washington. I want to thank you for your hospitality and particularly thank the Members for taking the time to come and spend 2½ or 3 days here in the San Francisco area to sense what the Western Medical Region is all about. I appreciate your support.

I'd like now to call on our first witness, Mrs. Nancy Reed, an occupational therapist with the Veterans' Administration.

Mrs. Reed.

STATEMENT OF NANCY REED, OCCUPATIONAL THERAPIST, VETERANS' ADMINISTRATION

Mrs. REED. Thank you, Mr. Chairman. I am Nancy Reed, an occupational therapist working in the community service section of the psychiatric outpatient unit at the Veterans' Administration Medical Center of Palo Alto at the Menlo Park division.

Today I am reporting on the outpatient programs for occupational therapy as utilized, and the significant impact they make on the health care of the veteran.

Occupational therapy provides service to those individuals whose abilities to cope with tasks of living are impaired or threatened by physical injury or illness, psychological or social disability, or the aging process.

The occupational therapist uses specific activities or methods to develop, improve and/or restore the performance of necessary functions, compensate for dysfunction and/or minimize debilitation.

At the Menlo Park division, we have four occupational therapists who are members of a multidisciplinary team in the outpatient services department. The newest program, which is one of 42 such programs in the VA system, is the hospital based, home care known as HBHC. The program began in August 1983, and has an average patient census of 43 with a projected target of 50 to 60.

HBHC is an extended care program under the auspices of the Geriatric Research, Education, and Clinical Center, or GRECC. It provides primary care services to homebound veterans using multidisciplinary teams which are composed of physicians, nurses, occupational therapists, social workers, and dietitians. There are several groups of patients whose particular needs can best be met by the HBHC team.

These include veterans who are postacute medical or surgical hospitalization, the terminally ill, recipients of care from multiple clinics, or those at risk of frequent hospitalizations or nursing home placements. The goal of HBHC is to enable the patient to remain in the home environment through the delivery of health care services and community resource referrals.

The occupational therapist is instrumental in providing home modification assessments, evaluation and training for a depth of equipment, individualized therapy exercise programs, and training in the activities of daily living.

The community training center (CTC) is a more structured program than the related ones within the VA system. It was established to treat predominantly severe chronic patients upon their release from the hospital and to provide an ongoing social support system that will help keep them out of the hospital.

Skills are taught that will enable the veteran to function as independently as possible within the community through classes stressing social and life management skills and through individual and group counseling. The programs attempt to provide a transition from the hospital to the community and to provide the tools to help the veteran be successful in establishing independence.

A daily average of 43 veterans attend the program which made a total of 6,797 visits for the fiscal year 1983.

The CTC team is comprised of a nurse, occupational therapist, psychologist, health technicians, and social workers. The occupational therapist shares the duties equally with the other members of the multidisciplinary team.

The activities of daily living such as grooming, money management, specific sensory integrative techniques, motor skills, object relationships, vocational skills, and redirecting energy into pur-

poseful activity, are areas in which the occupational therapist is involved.

Our third program, community services section, known as CSS, is a unique one within the VA system. CSS provides followup services for veterans in each of two regions on the San Francisco Peninsula who are living in the community. CSS is divided into two teams: northern and southern, comprised of a social worker, occupational therapist, nurse, dietition, and health technician.

CSS provides continuing inhome followup services to veterans placed in community facilities after hospitalization. CSS's task is to insure, No. 1, fair and equitable fees for the services provided; No. 2, opportunity, encouragement, and support in being as active and self-sufficient as his abilities will allow; No. 3, continuing supervision of and protection of the veteran's health, hygiene, moneys, and medication; and No. 4, a living environment that meets the legal and safety requirements of State licensing and that is well maintained.

The total number of veterans served for fiscal year 1983 was 455. Total patient visits were 13,089 with the recidivism rate of 16.48 percent. The southern team works out of the VA Mental Health Services Satellite in San Jose, which is approximately 40 miles south of San Francisco.

The occupational therapist is a case manager for 30 to 45 veterans and provides consultation to team members on problems in which rehabilitation, medicine, and occupational therapy knowledge are particularly applicable.

In the San Jose clinic, the occupational therapist is also involved with the veterans workshop which provides shelter and employment for veterans living in the community.

In summary, I would like to emphasize that occupational therapy focuses on the functional abilities of the veterans since the trend is to shorter hospital stays and for long-term management within the communities. I would like to recommend inclusion of occupational therapy in planning for future programing.

I appreciate your interest today and will be happy to answer any questions that you may have.

Mr. EDGAR. Thank you very much. Mrs. Reed, I wonder if you might just tell us briefly your background and the number of years you've been in this field?

Mrs. REED. I've been working with the Palo Alto VA Hospital for approximately 16½ years. I have had experience working with the psychiatric women's clinic. I have worked with the physical disability clinic where I was also supervisor of the psychiatric OT students during their internship and have been for 6½ years at the community service section with the southern team.

Mr. EDGAR. I am particularly interested in your community relationship, particularly in trying to provide care to veterans in their home or in their community as opposed to the institutional setting.

Now, as I understand these three programs which you focused on, their interest is to try to get the veteran out of an institutional setting as quickly as possible.

Mrs. REED. That's right.

Mr. EDGAR. Do you provide treatment for a number of veterans who live at home and have family members who try to provide care interspersed with the community care that you're providing?

Mrs. REED. The majority of the veterans that we treat are living in board-and-care homes, or what we consider licensed board-and-care homes. We have a small minority, I would say a small percentage of those are living with their families. The majority are with other——

Mr. EDGAR. The portion of veterans that live with their families, what are some of the problems that they particularly face?

Mrs. REED. In adapting to the community. They need help in being hooked up with community resources and in finding places where they are welcome in picking up their daily—the hours during the day and where they can receive care if needed.

Mr. EDGAR. We were talking yesterday about the whole area of age and medicine, trying to help the aging veteran. We were talking about respite care which would place somebody in an institutional setting for 1 or 2 or 3 weeks to free up the family members for that period to get recuperated themselves and refreshed to go back to the arduous task of caring for certain veterans that have certain kinds of needs and disabilities. This would be particularly beneficial for aging veterans who can't always function for themselves.

Another part of that are the training programs provided in training family members to do the kind of community service. Do you do any of that in the three services you have outlined?

Mrs. REED. We don't have a respite program within those three services. As far as working with the community services section, some of our patients who have a need to maybe go back in the hospital for a short time, which is what we consider respite, but we don't have an occupational therapist involved primarily in our respite program.

Mr. EDGAR. Do you know of any contract services in the area that provide services similar to those that you're providing?

Mrs. REED. Within the community? I'm not too sure of any particular community agencies that are providing it. We do have community agencies that do provide daytime activities, but not to the degree that we are. An interesting comment I do get from some of our boarding care operators where we place our veterans in the community, is that they like doing business with the VA because we are able to give the followup care where they are not able to get the same kind of service from community agencies.

Mr. EDGAR. Thank you for your testimony. It's very helpful. One of the things we've promised ourselves as a result of our hearings was a final recommendation and report. In Washington we want to see what we could do to encourage the institutionalization of veterans in particular areas where we can save Federal and State resources that are very limited.

And yet at the same time we want to be imaginative in ways that we can provide care that is noninstitutional care. Your testimony is very helpful in that area.

Mrs. REED. Thank you.

Mr. EDGAR. I'd like to yield to my colleague, Mr. John Paul Hammerschmidt.

Mr. HAMMERSCHMIDT. Thank you, Mrs. Reed, for your very fine statement. I notice your very professional background, your long-time experience in occupational therapy.

Mrs. REED. Thank you.

Mr. HAMMERSCHMIDT. Are there enough occupational therapists in the system?

Mrs. REED. There's not a shortage of occupational therapists. It's a growing profession in itself. Here in the Bay Area, because of the San Jose State University which has a training program for OT's, there's quite a few in the Bay Area. But in the Midwestern areas there may not be as many occupational therapists as needed.

Mr. HAMMERSCHMIDT. Is there any time limit you put on these services to a veteran?

Mrs. REED. Within these three programs? For the hospital based home care, I'm not too sure since that's a fairly new one. With the ones that we serve through CTC community service section, there's no time limit. It's an ongoing——

Mr. HAMMERSCHMIDT. Do you act as sort of an ombudsman for them?

Mrs. REED. That's true.

Mr. HAMMERSCHMIDT. In guiding them through a lot of different type services, do you get them into vocational rehabilitation and job training and that sort of thing?

Mrs. REED. That's true. Yes, that can involve that also. We do have a vocational counselor there through the VA that we can hook them up with. After we see how they do with our shelter workshop program, we do try—if it's applicable to the particular person, we do find the majority of the clients that I work with that they may not progress on to competitive employment, that they would stay right within the sheltered workshop.

We do find there is a need for the continuing of the shelter workshop program.

Mr. HAMMERSCHMIDT. And then do you follow through and see how successful the retraining program is?

Mrs. REED. Yes, we do.

Mr. HAMMERSCHMIDT. Until you feel that they are stabilized in society?

Mrs. REED. That's right. It's nice to have success stories.

Mr. HAMMERSCHMIDT. Thank you very much.

Mr. EDGAR. Thank you. Are there additional questions from my colleagues? [No response.]

Dan Mica.

Mr. MICA. I might just ask. I note in your testimony you talk about dealing with terminally ill. Is that in a hospice type setting or approach or is that—what do you do in a case like that?

Mrs. REED. A hospital based home care is where they would primarily be treating the terminally ill, and that's where the person who is receiving this service has to have a caretaker who will go out to the home where the person is staying to instruct the caregiver as to how to best meet the terminally ill person's problems, and in order to keep them out of the hospital as much as possible. That person may come in for a short-term hospitalization and then go back out to the home as long as he is able to.

The team members, whether it be the nurse, occupational therapist, or dietitian, would go out to the home to work with the family along the terminal period.

Mr. EDGAR. Let me just ask one additional question then and then we'll move to our next panel. The question is just one of speculation. In the San Francisco area you have the rich resource of four or five medical hospitals in a relatively compact area. In northern California, about a third of California with sparsely populated areas of veteran population, you don't have those metropolitan centers to provide the relationship between the hospital and the patient.

Do you have any suggestions for rural communities as they relate to the programs you have outlined, or sparsely populated areas for getting the similar kind of service going?

Mrs. REED. I think maybe the only suggestion I could offer would be like a satellite clinic which is probably run on a lot smaller scale. We have a satellite clinic in San Jose as I had mentioned, and we have a majority of our veterans who are treated at the Menlo Park, and some at Palo Alto that live in the San Jose area because it's less expensive to live down there. I would think that a satellite clinic could be set up within the smaller areas.

We also have a medication clinic that is conducted down there and there are plans in the immediate future to expand the San Jose program because of the growing needs of meeting the veterans in that particular area. And they come from as far south, I believe, as Monterrey-Salinas area.

Mr. EDGAR. Thank you. We were in Denver recently and John Paul and I were speculating about the possibility of a veterans air force that would take specialists around the country. We were only teasing. I hope everybody realizes that. You are allowed to laugh in a courtroom.

But we were teasing about how we would move people quickly to get to where those veterans are.

I appreciate your taking seriously our questions and really taking seriously our mission which is to look at the future of veterans health care and to look at innovative ways to provide that care.

Thank you very much.

Mrs. REED. Thank you. I enjoyed being here.

Mr. EDGAR. Our next set of witnesses will be Mr. Richard Countryman, Director of the Arizona Veterans' Service Commission, and Mr. Lou Blakely, Unified Arizona Veterans. Would you gentlemen come forward.

Mr. Countryman and Mr. Blakely, we appreciate your presence here today. The full text of your statement will be made a part of the record. There's no need to read every word and every line, and if you could summarize, that will be very helpful. Also in your statements, if you could identify what the United Arizona Veterans Service Commission is, what it represents, it would be particularly helpful to us.

STATEMENT OF RICHARD COUNTRYMAN, DIRECTOR, ARIZONA VETERANS SERVICE COMMISSION

Mr. COUNTRYMAN. Thank you, Mr. Chairman. I am Richard Countryman, director of the Veterans Service Commission. Mr. Blakely is here with me today. He will make a statement when I finish. The Unified Arizona Veterans, which Mr. Blakely represents, consists of all of the major veterans organizations that have a presence in Arizona. They have banded together as the Unified Arizona Veterans to present a united block of opinion of the veterans' needs, primarily legislatively, at the State level and some times, such as now, at the Federal level.

We certainly do appreciate, Mr. Chairman, your committee and yourself taking the time to hear from us in Arizona. We have, we think, some rather unique problems.

Due to our population explosion in Arizona, our three VA medical centers are taxed right to the limit. At the time that they were each built and designed, they were never intended to care for the number of veterans that they are presently caring for.

Additional funding, if it was provided right now, would still render it impossible to correct the present problem that we are facing. We firmly believe that some of the northern States and Midwestern States are going to have to give up some of the funding that they now enjoy so that other States in the Sun Belt and in the southern part of the country such as Arizona will have enough funding to provide care for the veterans that are now residing in Arizona and other places where veterans have moved to.

Our three VA medical centers in Arizona do an outstanding job, but they can't perform miracles. Recently in Phoenix, Ariz. at the VA medical center, it was taking 7 weeks to get a prescription refilled. In another case that we have identified—and there are many similar to it—it took a veteran 102 days to get to the clinic that he needed to get to through the maze of going through different procedures, seeing different doctors, to authorize him to be in the clinic where he needed to be to get the care he needed. We feel that that can be corrected, and of course you know it all costs money.

It is simply a case of not enough resources across the board at the medical centers in Arizona, both in the money, staff, space, including parking spaces. Many of our areas in Arizona where a lot of veterans live are far removed from the three medical centers. We have for our Indian veterans, for example, a Navajo reservation where there are approximately 14,000 veterans. The VA is sort of a myth to them. They leave the service, left the service at the time of World War I, World War II, Korea, and Vietnam, and live the rest of their lives and never see anything from the Veterans' Administration.

We feel that Arizona is a prime candidate for outpatient clinics. The only outpatient clinics are those at the three medical centers. We understand that there is an experiment going on in Colorado with vans. The director of the medical center in Phoenix doesn't favor that system. I think the veterans in Arizona, though, would welcome the chance to try it because something is better than nothing. And right now, in those remote areas, they have nothing.

We also in Arizona were astounded to learn that the Veterans' Administration planned to build a spinal cord injury center in Salt Lake City after they had just completed, in cooperation with the Paralyzed Veterans of America, a very comprehensive study that indicated that one of the highest percentages of paraplegics and quadriplegic veterans live in Arizona. Several thousand more live in Mexico and regularly cross the border back into our country to receive treatment at the VA Medical Center in Tucson primarily and frequently in Phoenix. Yet there is no spinal cord injury center in Arizona.

We feel that the VA Medical Center in Tucson would be ideally suited for that since they are working directly in cooperation with the University of Arizona School of Medicine.

Finally, we realize that this isn't a hearing on cemeteries, a problem that certainly affects the mental health of every veteran in Arizona, at least his mental attitude, the fact that the veterans in Arizona cannot be buried in a national cemetery in their own State.

Originally the veterans in Arizona, some years ago, were told that if their State would establish a State veterans cemetery, it would be very easy to convert it to a national cemetary. After we have done that, we are now told by the present administration that we should be buried—if we want to be buried in a national cemetery—we should be buried in Riverside, Calif., that the regionalization process was so set in cement that it can't be changed and we can't have a national cemetery until the one in Riverside is closed and full.

We don't accept that. We don't ever intend to accept it.

Again, I want to thank the committee for hearing our comments and receiving our written testimony. I know I speak on behalf of all the veterans of Arizona, that we are very willing to give our complete trust in the House of Representatives Veterans' Affairs Committee. They have always taken care of our veterans and I'm sure you always will.

Thank you very much, sir.

[The statement of Mr. Richard Countryman appears on p. 66.]

Mr. EDGAR. Thank you very much. Mr. Blakely, if you will, summarize your statement for the record—and then we will get to the questions.

STATEMENT OF LOUIS G. BLAKELY, UNIFIED ARIZONA VETERANS

Mr. BLAKELY. Mr. Chairman and members of the subcommittee. The Unified Arizona Veterans is a group of veterans organizations that have joined together for the purpose of representing all veterans throughout the great State of Arizona to promote all worthwhile endeavors of veterans organizations.

I am pleased to have the opportunity to present some views of the UAV in regards to inpatient and outpatient Veterans' Administration health care in the State of Arizona.

The most serious issues of importance to the veterans served by the Veterans Administration Medical Centers in Arizona is whether adequate medical care can be offered to the veterans presently as well as in the future. With the hospitals presently unable to pro-

vide full medical care, it is only reasonable to assume that the medical services will not be sufficient in the future unless the resources become available. Those resources being appropriate space, staffing, equipment, and funding for specialized services.

Also, adequate resources are needed so the VAMC's can manage the additional administrative requirements that have been imposed on them and the additional workload caused by the expansion of eligible access to the VA health care system.

We feel that an additional allocation of funds is not necessarily required, that a redistribution of moneys already allocated to the VA hospitals in States of declining population to the Arizona VAMC's would aid in providing adequate veterans' health care in the Grand Canyon State.

Another means of income that could and should become available is the reimbursement of insurance funds for patient care in the VAMC's. These funds should be returned to the VA health care system and not the general fund. Possible congressional action would be required to enforce all insurance companies not to restrict payments to the VAMC's for patient care.

The one factor that has caused a serious concern to confront our VAMC's in Arizona is our explosive population growth. In 1970 there were 234,000 veterans in Arizona. By 1980 this escalated to about 342,000 veterans. In 1983 there are 385,000 and maybe as many as 399,000 veterans of whom at least 35,000 are service-connected disabled veterans.

During the winter months, the veteran population swells astronomically as the migration of snowbirds arrive from the Northern States to escape the severe cold.

Arizona's growth between 1970 and 1980 was 53.5 percent. The population projections indicate the State will have 5.6 million in year 2000, up from the 2.8 million presently. The veterans' population will jump to 469,700 by 1990 and to an unbelievable 507,300 by the year 2000. It would be wise to plan and build for the expected influx of the additional veterans' population in Arizona now and not have to resort to catchup tactics later on.

Commonsense tells us that by putting off to later what is needed now will only cost many more dollars in the long run.

At the start of World War II, when the brave defenders of Corregidor were cut off from all aid and assistance, their radio messages were signed off with the declaration, "We're the battling bastards of Bataan, without mother, without father, without Uncle Sam."

The veterans of the great State of Arizona hope that their declaration will be something like "Our sufficient veterans health care was saved by our congressional leaders back in 1983, leaving nothing for despair. It was simply because they cared."

Thank you, Representative Edgar and members of this subcommittee for your concern over the serious decline in veterans' health care. The veterans certainly deserve better health care than they are presently receiving and hope to receive in the future. The members of this subcommittee can be our salvation.

I thank you on behalf of the Unified Arizona Veterans.

[The statement of Mr. Louis G. Blakely appears on p. 77.]

Mr. EDGAR. Thank you very much. I'd like to yield for questioning at this point to our expert on snowbirds and increased population of veterans in areas, the Honorable Dan Mica.

Mr. MICA. Maybe I ought to come down there and testify, Mr. Chairman, and trade places with Mr. Countryman and Mr. Blakely. I'm with you 100 percent.

I'm a Congressman from Florida and everything you said—-

Mr. BLAKELY. I love you.

Mr. Mica. Everything you said and everything that you projected here has already happened in our State and one example of what has happened, we are behind. I call Florida a catch-up State, and I don't mean tomato catsup. I mean we're catching up in veterans problems, in social security problems, in roads and transportation, post offices. We've already seen it. Everything you're talking about. I ought to be down there testifying with you.

We have a facility down in Miami, Fla, one quick example, designed to see 100 people a day, outpatient clinic, 100 a day. Do you know how many a day it sees, and it has seen every day for the last 5 years? Over 1,000. And you know how many hours they have to wait, days and days to get in. So, I understand. Now, I'll be an advocate on this committee for what you're talking about because it does pay now. It is a savings. I know there are a lot of Californians in this room and boy, I'll say, that old adage, you don't appreciate what you have until you leave it, they ought to leave California for a day or two and come to Florida or Arizona to see what we have to put up with. I can tell you when a California veteran comes to Florida, and comes to one of our hospitals, they really do face some problems. So I agree.

Let me ask you a few quick questions just to get the size of your problem. Are you serving at all non-service-connected veterans in your facilities?

Mr. BLAKELY. Very limitedly, yes. Several years ago, it wasn't a bit uncommon for non-service-connected veterans to receive outpatient treatment as well as inpatient treatment. The non-service-connected veteran now is receiving no outpatient treatment at all. And it's getting more difficult by the day for them to receive hospitalization.

In emergencies, they are being taken care of. Other than that, they are being turned away.

Mr. MICA. We have potentially the same situation in Florida. We just don't see non-service-connected unless it's an emergency. We cut that service out some years ago, about 2 years as I recall.

Let me ask you this on the growth rate: Do you have any projections over the last few years how many veterans a month, or a year, are moving into your State, the veterans population?

Mr. BLAKELY. The influx monthly?

Mr. MICA. Or yearly.

Mr. COUNTRYMAN. We don't have that with us. We figure in the snowbird category—I guess that's probably not a very nice term to use, it's one we're very familiar with.

Mr. MICA. We use it, too.

Mr. COUNTRYMAN. We feel that we can fairly prove that during the most severe months of winter, that our veteran population increases by 20 percent. And during those months, it's just impossible

unless you're on a deathbed to even go near the VA medical centers.

Mr. MICA. Well, I won't take all the time. I know other members have questions, but just between you and me—and we won't tell the rest of the folks in this room—in your testimony you mentioned a little bit about those northeast veterans, at least one or two people from this committee are from that area. So we want to say to them, in effect, we know you have needs, and we know that you are trying to meet the needs of your veterans. We don't want to take away, we just want the same type of service for our veterans in Arizona, in Florida, in Arkansas, throughout the Southwest, Southeast, and wherever veterans are moving because of weather or economic conditions or whatever it is. I think that's a right.

You served us. You served your country. We ought to serve you, and we ought to serve you the same way in Florida or Arizona or St. Louis or California.

I will close by saying that California system that we've seen here today is phenomenal. They have a great system. They're doing an excellent job. We intend to try to be of service to you and I'll try to speak up a little bit for Arizona when I'm on that committee talking about Florida problems.

Thank you.

Mr. EDGAR. Thank you. Are there additional questions?

Mr. Penny.

Mr. PENNY. Mr. Chairman, I may have missed it in the testimony, but I'm interested in knowing the status of outpatient clinics in Arizona right now.

Mr. COUNTRYMAN. Mr. Chairman, if I might answer that. There are three outpatient clinics, one at each one of our three medical centers. That is all. There are no independent outpatient clinics. And as I said, in many areas of Arizona, Kingman, Ariz., for example, is far removed from any VA hospital. Northeastern Arizona, which is primarily the Navajo Indian Reservation. As I said before, there are many, many Indian veterans who come back from the service and that's the last they ever hear. At the separation center, they may be told that the VA will take care of them medically.

But it becomes a great myth with them because they live so far from the VA medical centers that it's something that they finally forget about and give up on.

Mr. PENNY. How much pressure do your centers receive during the winter months? Can you give me a quantitative analysis, increased waiting time per patient at those clinics, or some other documentation, to just show the kind of increased pressure that the veterans from the North who vacation down there are providing for your system?

Mr. COUNTRYMAN. I would say they are at least doubling the waiting time. This goes right across the board. I have occasion to go over to the medical center in Phoenix quite frequently, and Mr. Blakely can verify this too because he's one of our commissioners on the Veterans Service Commission. Parking is out of this world. There just isn't any parking space.

And when you get inside, it looks like you are at a supermarket during a huge sale and I have waited—I'm serviceconnected for a sinus condition. I've waited 6 hours to see a doctor to renew a pre-

scription for sinus medicine, and then I've waited another several days to have the prescription filled.

And recently, as I said, it was taking 7 weeks. If you mailed a prescription in for refill, it was taking 7 weeks. It's at least doubling the waiting time in the winter months.

Mr. PENNY. Are most of the vacationing veterans residing in the highly populated areas, near one of these veterans facilities?

Mr. COUNTRYMAN. Yes; either Phoenix or Tucson.

Mr. PENNY. OK.

Mr. COUNTRYMAN. When I say Phoenix, of course, we're talking about Phoenix, Mesa, the greater Phoenix area.

Mr. PENNY. The metropolitan area there.

Mr. COUNTRYMAN. Again, northern Arizona is quite cold and has severe snowstorms and so the snowbird problem is in southern Arizona near Tucson and Phoenix.

Mr. PENNY. Pardon that question. I have never vacationed in Arizona, so I had to ask, but I do have a lot of friends and neighbors from southern Minnesota that spend 3 or 4 months a year down in your State and some who spend some time in Texas and Florida, so I'm quite sensitive to the kinds of pressures that their presence is placing on the veterans' facilities in the southern region.

Mr. COUNTRYMAN. If I might add to that, sir, the veterans from the northern areas are quite amazed when they get into the medical center in Phoenix and Tucson that they can't get the same good service they're accustomed to at home.

Mr. PENNY. It is true that the Northern States, we generally have shorter waiting periods, and the VA facilities, for the most part, are able to do more to serve our non-service-related veterans just because we don't have the kind of demand for services that you do in the South. Somehow we've got to be able to strike a balance. We do have some aging facilities in the North, and we have an aging veterans population up there as well. And what this committee is trying to do traveling around the Nation is to get a feel for what kind of balance can we strike, given the limited resources that we have.

Mr. COUNTRYMAN. We have every confidence that you will find it.

Mr. EDGAR. Thank you. If Marcy and John Paul do not have questions, I do have a couple of additional questions for you.

If you were to take the wall behind me and think of that as the State of Arizona, would you describe for us—so we can have a visual picture—of where the three medical centers are in the State of Arizona. Let's use this wall as the State.

Where's Phoenix?

Mr. BLAKELY. Phoenix is in approximately the center of the State, east, west, north, and south.

Mr. EDGAR. Can we use the——

Mr. BLAKELY. Let's say the seal——

Mr. EDGAR. The seal will be Phoenix?

Mr. BLAKELY. Will be Phoenix—125 miles south of that is the great center of Tucson.

Mr. EDGAR. OK. Tucson would be right below the seal 125——

Mr. BLAKELY. 125 miles, approximately south by southeast. Prescott, Ariz., is 90 miles north of Phoenix. It's in a slightly north by northwest direction.

Mr. EDGAR. OK. Prescott would be northeast which would be over here or over here?

Mr. COUNTRYMAN. Northwest, I believe.

Mr. BLAKELY. Northwest.

Mr. EDGAR. OK, northwest. It would be over here. OK. Are there any other major population centers in the State of Arizona?

Mr. BLAKELY. Yes. We have nothing as large as Tucson, of course, but we have Yuma, Ariz., and we also have an upcoming Flagstaff area which is a great tourist area now. And also an area up—north of the Indian reservations right on the northern border, right on the Colorado River, Page, Ariz.

Mr. EDGAR. What's the approximate population in the State of Arizona?

Mr. BLAKELY. 2.8 million.

Mr. EDGAR. I think it's helpful for us to know that different States have different unique properties and geographies and certain differences in terms of lifestyle and content. And you did state, very clearly for the record the problems that you face.

Apart from the major metropolitan centers that we see on the map behind me, it occurs to me that the State of Arizona is an essentially fairly dispersed State in terms of accessibility to the facilities that you've mentioned. You have three veterans' facilities, correct? Three veterans' hospitals with clinics located near them.

I think you're on the right track in asking for some help. I have a challenge and a criticism.

My challenge is that I think we have to ask how do you provide quality health care in remote and rural areas. How do you provide health care in some new ways. For example, are there some community hospitals in the area that we could establish a miniveterans' clinic next to, use the resources of the Federal Government and share those resources with a local hospital. Could we take the model of several vans going out from the medical centers into the rural communities to provide some at least primary health care services, recognizing the limitations when you have a van. You don't have a CAT scanner, you don't have a dialysis machine necessarily. You don't have a large amount of sophisticated equipment; but you could do medical kinds of evaluations.

How can we provide pharmaceutical services quickly and efficiently to your veterans who are out in those remote areas? Could we in fact utilize a small plane, as they do in the Denver area, to fly to a remote area 2 days a week to provide particular services, perhaps at a local hospital or a local clinic that would help to aid those veterans?

All of those kinds of imaginative ideas are things that we're thinking of. It would be helpful to me as a challenge if you would go back to your State and send to us a specific set of proposals, a wish list, if you would, of how, in the next 10 years, 20 years, you would like us to try to address the emerging population.

If I read your statement correctly, you move in population of veterans from about 300,000 to 500,000 veterans and the pressures with——

Mr. BLAKELY. By the year 2000.

Mr. EDGAR. Right. So if you could talk to your veterans' service organizations, to your Senators and House Members from that State, to your medical professionals in that State in terms of how to deliver health care, that would be helpful to us.

Now, just a small criticism. I'm not certain that people who make the statement, "Let's take away from the Northeast and Midwest and put it in the South," have ever sat in long hours of waiting for pharmaceutical services or clinic services in some of the hospitals in the Northeast and Midwest regions of the country. In the 18 States that make up a regional area from Maine to Maryland across to Minnesota and Wisconsin, we have 45 percent of the population and 65 percent of the unemployment. With people falling off the unemployment rolls, the incidence of use of veterans' facilities has increased as those people no longer have health care through Blue Cross and Blue Shield and other services.

Aging veterans is a serious problem throughout the Nation. We presently have 3.3 million veterans who are age 65 or older and in 7 years we will have some 7.7 million veterans who are aging veterans. You have them in Arizona. Dan Mica has them in Florida. We have them in Pennsylvania. A number of our facilities in the older industrial cities and States were put in place right after World War II. And the quality of health care that can be provided in those facilities is pretty limited because they don't have the space criteria and the health services criteria just to give the minimal quality health care.

I think it's a myth to think we can solve the problems of Arizona by taking away from another State. I think it's a reality to say that the problems in Arizona are severe, they're difficult, they've got to be handled, they've got to be administered in a constructive way. There have to be modifications of the Northeast and Midwest regions of the country in terms of rehabilitation and reconstruction of existing facilities, upgrading the quality of care, providing for efficiency of services there as well. I think it's important for us to hear your testimony and go into the State of Arizona and provide that service.

My caution is that if we begin to cannibalize each other and continue the civil and regional warfares that we've had in a lot of areas, water policy being one, human service areas being another, highway programs being others, that we're really not getting anywhere as a nation.

What I'd like to see us do is to begin to develop some strategy for providing the Veterans' Administration with adequate resources, provide for John Paul's Arkansas and Dan Mica's Florida and Bob Edgar's older Northeast-Midwest region of the country. And I should admit to you that I'm the vice chairman and former chairman of a group called the Northeast Midwest Coalition that tries to struggle with older industrial cities and States that have problems too.

So I apologize for——

Mr. HAMMERSCHMIDT. Will the gentleman yield?

Mr. EDGAR. Yes, I will yield to my colleague.

Mr. HAMMERSCHMIDT. I want to thank the gentlemen for their very fine testimony, and to tell them that we have the largest

budget we've ever had in the VA, $8.3 billion in the medical section alone; over $25 billion overall. They've added 2,000 employees in fiscal 1984 to the medical system. And yet we have this maldistribution of services. We recognize we have fast growing areas like Phoenix that we haven't caught up with in the system. And then you have those rural areas. I would say this about a statement that our chairman made. He was suggesting flying in specialists and doctors and so on into rural areas. The reason though—I think if he will think back—that Colorado can do this is that they are fortunate that they have a VA hospital out in the hinterlands, so to speak. So they can fly in specialists. But you don't have that, and so you have to think of some other way.

We would very much appreciate any ideas that you might have, so let us know how you think the VA can better deliver those services to your rural areas.

Thank you.

Mr. EDGAR. Thank you. I want you to go home knowing that your statement is important and we're not trying to underscore or underestimate the need that you have laid out. And I think if you can provide us with a record, some specific options for your State, we will go to work very diligently to try to provide at least for some of those specific options. And I hope that we can build a better partnership Northeast, South and West in providing veterans' health care throughout the Nation.

Mr. BLAKELY. We'll certainly provide the information. Thank you again.

Mr. EDGAR. Thank you very much.

Our next panel of witnesses will be Mr. Jack E. Brady, national junior vice-commander of the American Ex-Prisoners of War; Mr. Arthur P. Kruse, the executive director, Department of California AMVETS; and Mr. Edward F. Pittelkow, president of the bay area and western chapter, Paralyzed Veterans of America.

Gentlemen, we really appreciate your being here. As you can tell, we have lots of questions to ask and sometimes the chairman asks too many questions. We would hope that you could summarize your statements for the record.

We need you to sit, if you could move over slightly. We need you to be at least in striking distance of both the microphones, one provides for our reporter and the other for amplification.

Mr. Brady, I think we'll begin with your statement. If you will identify yourself for the record and any persons who are with you and we'll go through the testimony, and then we will raise our questions.

STATEMENT OF JACK E. BRADY, NATIONAL JUNIOR VICE COMMANDER, AMERICAN EX-PRISONERS OF WAR

Mr. BRADY. Thank you, Mr. Chairman. I am Jack Brady. I am the national junior vice-commander of American Ex-Prisoners of War. My companion on my left is Mr. Melvin Routt. He is the national director from this area.

Mr. Chairman and members of the committee, we want to thank you very much for the opportunity to appear here. I don't want to bore the committee by reading from the statement that's already

been prepared. I would like to point out before I begin any formal statement that we are all very much interested, not only in our own concerns, but in the concerns of all veterans because we are, of course, veterans.

If you will look over to your right, I believe you will find that just about the entire audience on that side is composed of members of this organization. It illustrates, I believe, the interest that they have in the concerns of veterans as a group.

Mr. EDGAR. Will the members from the prisoners of war please stand for recognition.

[Members stand.]

Thank you very much for coming. We appreciate it.

Mr. BRADY. Thank you very much, Mr. Chairman.

As I said, I'm not going to read from my statement. I'm not even going to read from this stack of material I have here in case you were worried by all that. But I do want to point out——

Mr. EDGAR. I was beginning to bite my fingers but I won't do that.

Mr. BRADY. I do want to point out that there are some things in my prepared statement that possibly should be a little more stressfully put. We greatly appreciate the work that this subcommittee—in fact, the entire committee—put into Public Law 97-37. It's been in effect now for about 2 years.

However, we are all over this country greatly concerned by what we feel is still a little bit of a backward—well, the VA is simply backward in the application of that particular law. By that I mean we all agree that the examinations we get under that particular public law are by far the best that we have received since we returned to this country as a repatriated or recovered American military personnel, or RAMP as we were called at that time.

However, we are now given an examination which lasts approximately 2 hours. When it was first discovered or thought that those people who were held prisoner in the Vietnam area, Southeast Asia, were to be returned, they were given an examination, as you were. I have to backtrack.

When it was first thought that they would be returned to this country, the Center for Prisoner of War Studies was established by the Armed Forces in San Diego. Using first materials which were furnished by the American Ex-Prisoners of War, they accumulated a large amount of additional literature. They came up with an examination protocol which took approximately 2½ to 3 days to complete.

As I said, the examinations we get now are something like 2 hours. Somehow or other I feel that the examinations we get are not quite so complete and as thorough as they ought to be. There is another point that I think that needs to be stressed—and that's the people who are doing the examinations. In some cases, the hospitals are using fee basis or fee physicians and in some, I understand, they are using brand new graduates where they are connected with a medical school.

There is not a medical school in this country that has a course which deals with the kinds of things that we are concerned with. Now, the reason for that is very simple. There aren't that many of us. There is no reason whatsoever for a medical school to teach a

doctor, or a group of doctors about people they probably will never see, and to teach them their ailments.

Since about 1969, I believe it was, the American Ex-Prisoners of War has had a medical research committee. This group of pamphlets is a result of that.

We would like very much to have one of these sets, at least one of these sets, in every single hospital or any place where one of us may possibly be examined. This contains information that they need to know about us. These are constantly revised. I believe these are the latest revisions.

We're a small outfit, which is very good, because that means there aren't very many of us to begin with. But because we're small, we're also rather poor. We can't afford the 200 and some odd sets of these pamphlets which would be required if each of the various medical facilities were to have a set.

However, the information contained in these pamphlets is invaluable to us as a patient and to the doctors who are examining us because this tells them what to look for. We are a unique group. It's unfortunate for us, but we are unique as far as this country is concerned.

A lot of this information did not originate in this country. However, this type of information must be made available to the doctors who are examining us and it not only must be made available, but they must study it.

Another thing that really bothers us is the use to which these exams might be put. We have heard, but we don't know how true it is. We haven't found anybody at a regional office yet who says that it's so, but we have heard that the results of these examinations may possibly be used as a means of—well, simply a survey for the purpose of determining what kinds of residuals there are in us.

Well, it's very well to be used as a guinea pig. But we don't appreciate that, if that's the case. We want the examinations to be used for treating those things which are found to be treatable or if it's not treatable, and we are disabled by some particular condition, we would like very much to be granted the same consideration for compensation that others are granted.

The last part of my statement that I'm going to mention that I think needs to be stressed is again something that will be touched on by Mr. Routt. We have had absolutely nothing but the best of cooperation from the people in the upper levels of management and administration of the Veterans' Administration. There are very, very few complaints about that.

However, when it gets down to the working people, the clerks we must deal with and in some cases the doctors we must deal with, that's an entirely different story.

I would now like to have Mr. Routt make his statement, please, unless you have questions.

[The statement of Mr. Jack E. Brady appears on p. 91.]

Mr. EDGAR. Mr. Routt, we look forward to your statement. Because of the pressure of time, we must ask you to summarize your statement as much as possible. Thank you very much for being here today.

STATEMENT OF MELVIN L. ROUTT, NATIONAL DIRECTOR, AMVETS

Mr. ROUTT. Thank you, Mr. Chairman.

As the national director, I travel all through California and visit the various hospitals, including those in Nevada. I would like to indicate some of the problems that we have found here.

Since the enactment of Public Law 97-37, and the troubles that we were having, the central office will interpret it one way. By the time it reaches from hospital to hospital, it will vary. In Medical Districts 27 and 26, under Dr. Upton and Dr. Morse, they're making drastic changes to improve this and I think will in time.

The programs such as agent orange and nuclear exposure and the bills passed by Congress with good intentions do not have the additional staffing or the finances to carry out the program as it was meant to be implemented.

Medical training teams are needed to be established from the central office and sent out to the various districts so that the uniform of the program will be complete. In other words, from hospital to hospital it will be understood under that condition.

As the medical program under the VA Form 10-004A, which is used to do our medical examinations, to fill in the void of the medical records which the enemy did not keep. This form was meant to be put in the records for future reference, or for opening a claim, or automatically opening a claim that had been denied. Central office encouraged all ex-POW's to fill out the form.

However, we found in one of the areas in San Diego that before they would give them the form at all, they would have to open a claim. Now, this was not the intent. I hope that that has been corrected at both the regional office here and elsewhere.

The data card, which has a definite format, was initiated last year by the central office. Sometimes it is not understood in the hospitals and a vet will have to go to one of the other hospitals to get the proper status and POW marked upon the card.

One of the other things which we find a great waste of time and money to the POW's is that after starting the examination for evaluation under the new protocol, perhaps 2 or 3 weeks after the first appointment we must start over with another doctor. I realize that it will take different doctors for different problems, but it should not be necessary to start all over again.

The problem of standardizing the whole system seems to be lack of communication and education. The cooperation from the administrators of the hospitals, chief of staff are all good, including central office. But somewhere between them and the GS-4's, GS-5's or GS-3's who are the first we associate ourselves with, we are lead astray and the whole program is from then on a mess.

So it's a matter of education and I have great reasons to think that it will improve. But I would like to make a recommendation for a training program started from central office, carried out from central office to the various districts, so it will be uniform.

Thank you.

[The statement of Mr. Melvin L. Routt appears on p. 96.]

Mr. EDGAR. Thank you very much. Mr. Kruse.

STATEMENT OF ARTHUR P. KRUSE, EXECUTIVE DIRECTOR, DEPARTMENT OF CALIFORNIA AMVETS

Mr. KRUSE. Thank you. I am Arthur R. Kruse, executive director of the AMVETS, State of California. And I have been given a statement that, if it's all right with the chairman and the committee members, about 1 minute, I'd like to read it.

Mr. EDGAR. The gentleman is yielded 1 minute.

Mr. KRUSE. Thank you. This statement expresses the apprehensions, anxieties, and interest of literally thousands of military veterans served by the Fresno, Calif. Veterans' Administration Medical Center.

The facts related herein are not common to that one facility alone, but concern every VA medical center where an affiliation program has been instituted, integrating the VA medical center with an associated medical school of a university.

The basic problem is that the university medical school has made a power grab on this medical center, replacing dedicated physicians, administrative personnel of long standing, controlling allocated budget, diverting funds to their own purpose and changing procedures to suit their own needs.

This is all done to the disadvantage of the veteran population served by the VA. The most disconcerting fact is that the VA central office, as well as some of the VA hospital directors, are co-conspirators in an overall effort. Complaints to local Congressmen fall on deaf ears, and those veterans who realize the implications of the ultimate demise of the VA, feel powerless to alter this catastrophe.

In a briefing to the Congressmen by DM&S personnel and selected educators prior to the inception of the program, the realization of great benefits were envisioned. As it has proven to date, the sole factor has been to the university recipients.

Prospects for the demise of the VA medical program as forecast by the American Medical Association are looming ever more brightly.

As told to us by a regional office director 8 months ago, the VA has a plan to disallow all medical treatment within 5 years for non-service-connected veterans. Dr. Custis, in a recent newspaper article, related why NSC veterans who attain the age of 65 could not be accommodated in VA medical facilities. His statements are considered a forerunner of the VA plan.

As I said, Mr. Chairman, I didn't write that statement and I'll be glad to try to answer any questions pertaining thereto.

Mr. EDGAR. Thank you.

Mr. KRUSE. I'm also a VA volunteer service representative for Fresno Medical Center.

Mr. EDGAR. I appreciate your presence here. And I apologize for mispronouncing your name, but I mispronouce everybody's name, so it's equal all around.

Mr. Pittelkow.

STATEMENT OF EDWARD F. PITTELKOW, PRESIDENT, BAY AREA AND WESTERN CHAPTER, PARALYZED VETERANS OF AMERICA

Mr. PITTELKOW. My name is Edward F. Pittelkow and you pronounced it correctly. I am president of the bay area and western

chapter of the Paralyzed Veterans of America. The gentleman to my right is Mr. Ed Jasper, who is the chapter executive director and the past president of the national PVA.

Mr. EDGAR. Mr. Pittelkow, if I could interrupt you at this point. I note from reviewing your statement that you have some six pages of testimony to give and we do want to have some time here this evening to hear from the VA witnesses and to have countercomments. Your full statement will be made part of the hearing record. If you could summarize a little bit, it would be helpful.

Mr. PITTELKOW. I'll do that, Mr. Chairman.

Long-term care. We also, with our spinal cord injury, have the aging veteran. And this does create problems. I am going to cut it short, and in fact I'm going to stop right now because I can't read without notes.

That concludes my statement, and I thank you very much.

[The prepared statement of Mr. Pittelkow appears on p. 98.]

Mr. EDGAR. In your prepared statement you make some really important specific comments about specific needs in terms of long-term care and in terms of personnel. Some of the solutions that you have laid out here, particularly on pages 3 and 4 are very helpful to us. We do have some questions that we want to ask you in that area.

Thank you. I apologize for drawing all of your statements to an abreviated format, but it's important for us to receive this information, and we would like an opportunity to question your comments.

I might say that we did have an opportunity to visit Palo Alto yesterday. I was particularly pleased to have an opportunity to observe some of the research that is being done there, particularly in wheelchair development and in some of the new technologies. And while it has not moved quickly to human application, there are some signs that on the horizon there will be a number of the chairs utilized for human application.

Mr. PITTELKOW. We're very proud of that center.

Mr. EDGAR. I looked a bit silly yesterday with my suit and tie sitting on a two-wheel bicycle that they had made for paraplegics and able to wheel that bicycle with my hands around a couple of the streets there. It was an exciting opportunity and everybody was sure I was going to ditch someplace in a gully, but fortunately I stayed on.

I also had the opportunity to ride in a wheelchair that was computer operated and controlled much like the hand held mechanisms that you would use for computer—a joystick. And I was very impressed with that. I think it pointed out to me one of the real important reasons for us to do field hearings. We can sit in Washington in rooms that look much like this room and have testimony, the people giving us words from the medical director in Washington and the other people who testify. But it's not until we actually have visual sighting of some of the research improvements and some of the medical improvements that we really understand what we're talking about.

We had the opportunity in Chicago to visit a spinal cord injury center and we've had the opportunity to look into in some detail what the VA has done in the past and needs to do in the future to provide quality care in that area. To see the improvement that's

made by many of the patients that are serviced through the VA is just as phenomenal. There are problems. There are staffing problems, personnel problems and financial problems, but it's just as important for us to see that.

I'd like to yield to my colleague, Marcy Kaptur. She may have any questions at this time.

Ms. KAPTUR. Yes. I'd like to thank all the excellent witnesses on this panel. I have so much to say and no time. I know time is limited. I just want to say to Mr. Pittelkow and Mr. Jasper, yesterday, when we were at one of the facilities in Palo Alto. If I'm not incorrect, we were lectured—they were showing us all these fish that they brought in from the South Pacific and how they were really doing research on nerve regeneration and how this particular fish was able to replace its own spinal cord after it had been broken and it was the only fish in the world that could do that. What was clear to me was that some of the most innovative and important research going on in the country in the area of spinal cord injury is happening right here in California. And I guess you're fortunate, more fortunate than those of us who live in Ohio, for example, and I think it bodes well for the future and it was most exciting. I think some of the researchers we met were fascinating individuals. They showed us slides of some of the cells they were studying in a effort to understand how they reproduced themselves. I was inspired by what I saw yesterday.

Mr. Kruse, I'm not going to ask you any questions but just say that later this afternoon we're going to hear from the Director of the VA Medical Center in Fresno, and I will, along with others here, probably ask a little bit about the criticisms that you raise.

But I wanted to direct my questions to Mr. Brady and to Mr. Routt if I might. I'm a new Member of Congress and was not in Congress when Public Law 97–37 was passed and I'm interested in two or three things.

First of all, in addition to what you said in your testimony, have you found the VA receptive in changing internally? You've talked about some of the difficulties with lower level staff. But we know we have to be patient as we embark upon change. I wanted to ask more of a question on judgment as to whether things are better now than they were before the passage of Public Law 97–37, even though we have a long way to go. That's my first question, and I have two other short ones.

Mr. ROUTT. In California, yes, they are improving slowly. I think, as I stated before, it came, started. The tremendous turnover of VA employees in lower pay grades contributes to the problems. They are forever starting there and then they move into a higher position or something. They are always training personnel in that. So a training and education program would do us a lot of good.

As far as the medical packets are concerned, I can say that in California all the hospitals have them. We've either donated them or they were bought, so they've been helpful.

Ms. KAPTUR. I wanted to ask you. On the case histories that you mentioned there, have those been medically reviewed? It wasn't real clear to some of us on the panel what was contained in those, and perhaps we might have them reviewed by the committee,

make them part of the record, and submit them if that makes sense. But could you tell us a little more about what's in there?

Mr. BRADY. I'm not sure that I understand what you mean by case studies.

Ms. KAPTUR. Well, what you're holding in your hand, the medical histories of——

Mr. BRADY. These are not necessarily medical histories. These are extracts from the medical literature which have been obtained by research by our medical research committee from the literature which goes back, in some cases, clear to 1890, on the effects of incarceration, the aftereffects, residuals, all that type of information. But this is the material that doctors do not study here in this country. These are the kinds of things that the medical schools don't bother to teach because there is no need for them in this country.

However, I would like very much for the committee to have this set if you wish. I don't know of any other kind of resume or a precis to make of this thing. This is, in itself, extracts from medical literature.

Mr. EDGAR. Would the gentlewoman yield?

Ms. KAPTUR. Yes.

Mr. EDGAR. You have offered those to the committee and it would be helpful to have them. We'd like to make them a part of the file. It's slightly different than making them part of the record. If we make them part of the record, we have to reproduce them at great cost to the Federal Government and to the official record of the hearing.

So if you will present them to us and give them to Barbara Daniel, who is our staff person, we will make them a part of the permanent file of the committee and utilize them in developing a recommendation as a result of these hearings.

Mr. BRADY. That would certainly be satisfactory. Actually what I was hoping you were going to offer was that you would have these reproduced and distributed to all the VA medical centers.

Mr. EDGAR. Well, if the gentlewoman would yield further. I have counted them up and there are 172 hospitals, and if our recommendation is to reproduce them, it's a little cheaper to reproduce 200 of them than to reproduce 20,000 of them as part of the official record of the committee. And I appreciate your eagerness to do that.

My concern is that the VFW is sitting behind you and they may have some documents that they would like 20,000 copies of, and there are some other groups that may also want to do that. So just to start, if you would make them available to us, we will make them a part of the record, we will review them and perhaps parts of them we will include in the official record and then we'll proceed from there.

Mr. BRADY. Mr. Chairman, consider it done.

Mr. EDGAR. Thank you very much.

Any additional questions?

Ms. KAPTUR. No, thank you, Mr. Chairman. Mr. Kruse, I believe, has a statement.

Mr. EDGAR. Mr. Kruse?

Mr. KRUSE. We veterans here in California—speaking for myself—in the central area, we'd like you to take back to Washington, whoever in the VA Administration that put this out, he de-

serves a gold star and we're going to see that if he runs for office, he's going to get elected.

Mr. EDGAR. Well, let me respond, and I know—in fact, maybe I should let my colleague, John Paul Hammerschmidt, respond. We're very proud of the person who did put that out and I'll let him indicate to you who it was.

Mr. KRUSE. It's one of the few things in government that reached us really.

Mr. HAMMERSCHMIDT. Well, let me comment just briefly on that, if I may, Mr. Chairman. That came from our new Veterans' Administrator, Mr. Harry Walters. It was his idea, and he's promoting it. I was with Harry Walters day before yesterday. He was kind enough to come down to a dedication ceremony that involved all of our veterans' groups and we're very proud of him. He has the confidence of the Congress and the confidence of the President. For the first time in the 17 years that I've been in the House of Representatives, I went down with Harry Walters and members of the veterans' service organizations, your national commanders, to meet personally with the President.

Harry Walters arranged that. And he said to the President, Mr. President, you appointed me to this job. I'm going to be an advocate for the veteran. Is that what you expect of me? And the President said, yes. So we were delighted to hear that because we've had some disappointments in the past, but Harry Walters deserves all the credit.

Mr. EDGAR. I'd just like to associate myself with the remarks of Mr. Hammerschmidt and indicate that there is a great feeling on the part of the Democrats and Republicans, conservatives and liberals in Washington, that the quality of the Veterans' Administration has increased substantially with the addition of Mr. Walters and we're pleased with not only the bumper sticker but the enthusiasm of putting veterans first.

I'd like to yield to my colleague, Dan Mica, and then we'll move on.

Mr. MICA. Two quick points, if I may, Mr. Chairman. The first, with regard to the documents Mr. Brady has, I'd like to ask that the committee, when we return to Washington, seek a review of those documents by an appropriate individual in the VA with recommendations on where it would be inserted or used in regimen at various hospitals. Someone could come down and talk to us about it or the committee. And I'd like to at least have their assessments.

Second, Mr. Kruse, specifically has anyone told you, or has there been a public pronouncement about when these modifications were scheduled to be completed?

Mr. KRUSE. Yes. The contract will be fulfilled December 1983.

Mr. MICA. That's what was announced?

Mr. KRUSE. Yes, sir.

Mr. MICA. We're going to talk with the officials in a few minutes and we'll ask them about that.

Mr. HAMMERSCHMIDT. Dan, would you yield a minute?

Mr. MICA. Certainly.

Mr. HAMMERSCHMIDT. I just want to say, Mr. Pittelkow, that I've read your statement totally through and I imagine most of the Members up here did. You didn't get to present it all verbally so

everyone out in the audience didn't get to hear it. However, of course, it does become an official part of the record. It's very well organized. We noticed four or five major points on possible solutions to problems. We appreciate that very much.

Mr. PITTELKOW. Thank you.

Mr. EDGAR. Thank you very much. And I want to thank all of you for coming.

Our next panel will include Mr. Earl Gunnels, Jr., Commander, Department of California Veterans of Foreign Wars; Mr. Hal Goldman, Commander, Department of California, the American Legion; Mr. James T. Ruppenthal, National Service Officer, Disabled American Veterans; and Mr. Paul Battisti, Administrator, The Veterans Home of California—excuse me, I think he's on another page and I think we'll call him separately if that's all right.

If you three gentlemen will come forward.

I wonder if, at this point, since this is the last panel of veterans' service organizations, if all those who are representing these service organizations would please stand for recognition in the audience. All those besides the prisoners of war, if you would just stand.

[Members stand.]

Thank you very much for taking the time to be with us today.

We'll turn first to Mr. Gunnels and all three of your statements will be made a part of the record. I know some of you have prepared statements, some do not. We'd appreciate any summary that you could make, and noting that many of the issues have been dealt with by some of the previous speakers I would hope that you would focus on the unique issues that you bring to this committee. Thank you very much for your contribution.

STATEMENT OF EARL GUNNELS, JR., COMMANDER, DEPARTMENT OF CALIFORNIA, VETERANS OF FOREIGN WARS

Mr. GUNNELS. Mr. Chairman and members of the subcommittee, I represent 126,000 members of the Veterans of Foreign Wars of the State—and its ladies' auxiliary in the State of California.

There's not much I can add to my prepared statement. I'm not a service officer in my own right. We have 25 paid employees. One-third of our State budget is devoted to helping veterans who need help from the Veterans' Administration.

I have, in my travels through the State in the first 5 months of my term, seen several improvements in the buildings in the Veterans' Administration areas where I've been. These are going to be nice, but the major thing is we're going to have to have money to stock the doctors and nurses, the pharmaceutical areas, and have the pharmaceutical things available as well as the request for CAT scanners and other things that have not been turned over to some of the different hospitals.

We have a good relationship with our regional directors and the VAMC directors around the State, and I think they are doing an excellent job with the amount of money that they have. And that's their limitation, is money.

I want to congratulate the committee and thank them for placing agent orange—or the H.R. 1961 Agent Orange bill, before the

major part of the Congress, and I do hope it can be passed to help our Vietnam veterans who were injured. We were able to buy up a whole town in Texas. Evidently the Congress of the United States, up until now, thinks a veteran has a better skin, more impregnable than the civilians or his genes are different and are not affected.

Mr. EDGAR. Thank you very much for your statement.

[The prepared statement of Mr. Earl Gunnels, Jr., appears on p. 104.]

Mr. EDGAR. We will now hear from Mr. Goldman.

STATEMENT OF HAL GOLDMAN, COMMANDER, DEPARTMENT OF CALIFORNIA, THE AMERICAN LEGION

Mr. GOLDMAN. Thank you, sir.

I'm sitting before you as a result of a lot of medical treatment that I've received, both in military and VA hospitals. I speak not only as the Commander of the American Legion, but one who has survived or received some of that treatment. I commend it highly personally. I'll let you be the judge of that one when I get through with my statements.

You have before you our printed statement, and I will try to highlight some of the things that we are primarily concerned with.

The major sub-benefits, benefit adjustments, and we talk about the budgetary needs which everybody seems to be highly aware of. The quality of medical care and the contribution which we make on a voluntary basis to the many hundreds of thousands of man-hours that makes that quality of care at least reach the peak that it has at this point in time.

Both the American Legion and our fellow veterans' organizations contribute heavily and contribute a considerable part of their service to the veteran.

However, the need for long-term nursing care is a primary concern to us with the aging veteran coming fast upon us as you mentioned in your opening statement. Not only the World War I veteran and the World War II veteran, but the Korean veteran is also now becoming an age where he is just a few years away from the age of retirement. We are critically concerned about that type of care which we have heard is going to be cut off in the Veterans' Administration.

We are primarily concerned, and I know that I speak on behalf of the American Legion as well as myself, and we want the Veterans' Administration Medical Center care. We do not want to be incorporated into the community hospitals by any stretch of the imagination. We do not want to be put into the care of welfare cases. We earned the right to have this type of treatment and care specified as veterans' care.

We do want, as the others have mentioned here, the concern for our younger veterans and the agent orange studies. The American Legion has undertaken our own independent study to try to expedite what we feel has not been the most expeditious manner in the VA handling of that agent orange study.

Our concern now is also for the increasing number of women veterans and the needs that they have, both in OB/GYN, not so much the OB but the GYN care at the various facilities. It seems to have

been overlooked in many of the veterans' facilities, and we are hoping they will reach their full potential.

As to construction, yes, I concur and I sympathize with my veterans of Arizona and Florida, et cetera. But let me point out that we, here in the State of California, have 3 million veterans, more than any other State. In addition to that load which we carry right now, we do have visitors coming in from Nevada, Arizona, and some of the other ill-weather States in the midwinter, further burdening those facilities which we have during the various times of the year. We can point that out both in sunny southern California and in northern California. We run the gamut of weather out here.

One of the other things that we would like to make sure that is continued, and have not heard a mention of, is the burial allowance which we fought to bring back in Los Angeles through the Veterans' Administration with the indigent veteran left in a box waiting for someone to take care of him. We have conflicting laws that will not allow him to be cremated or buried in a boot hill, but they ought to receive their just due if they served honorably for this Nation.

In conclusion, Mr. Chairman and members of the subcommittee, I presented here certain matters that are of current importance to the American Legion. What the American Legion wants with veterans is what is fair and just. Working together, we believe the goals of fairness and justice can be achieved. As stated earlier in this presentation, the Veterans' Administration is not a perfect agency. Nothing that size can be. We do feel improvements can be made. We thank you for allowing us to present the views of the American Legion, the Department of California, before the Subcommittee on Hospitals and Health Care.

I do have some other side comments later on.

Mr. EDGAR. OK. Thank you.

[The statement of Mr. Hal Goldman appears on p. 108.]

Mr. EDGAR. Mr. Ruppenthal.

STATEMENT OF JAMES T. RUPPENTHAL, NATIONAL SERVICE OFFICER, DISABLED AMERICAN VETERANS

Mr. RUPPENTHAL. Mr. Chairman, 8 days ago Rick Heilman from our office in Washington called me and said our State department commander could not make it and gave me the job. Of those 8 days, I was laid up with my own disability for 6, so I would appreciate if you would hold the record open for about 10 days so I can get a prepared statement in.

Mr. EDGAR. Without objection, the record will be held open for your statement and your prepared remarks will be made a part of the record.[1] And we'd ask you to just simply summarize your observations.

Mr. RUPPENTHAL. Thank you.

One of the things I've noticed on our field service unit, which I went up to northern California in the late part of October, was considerable problem with fee basis cards. Such things as doctors refusing to take them due to paperwork and payback times, problems

[1] Not received at time of publication.

with preauthorization in that the veterans called the hospitals and when it was time to pay it was denied and said we didn't hear from you, these sort of things.

Problems with the medical fee schedule rate whereas the 1174 form says that the doctor, if he accepts the money is paid in full and will not go to another source to collect money from the veteran. This is not happening in all cases.

Problems with prescription changes and unauthorized claims.

Mr. Chairman, it's 360 miles from San Francisco to the Oregon border which we cover. Those veterans up there do not have the advantage of VA medical facilities which I'll get to a little later.

Part of the solution, I think, to some of these problems up there is an education program. And I think the service organization's program will be a very valuable one. If we keep better tabs on the changes as far as the budget goes, what's happening in the pharmacy and all this, we can get out to the veteran why these changes are being made, justified if possible, and make sure that there's a less hassle under the VA system if they understand what's going on.

It seems that the people running the program are at a higher education level than the people receiving the benefits. It is very difficult for some of these veterans to even understand. For example, this 1174 fee basis card is very small print, for one thing. It's difficult for some of these veterans to understand why they have to go through all this paperwork and that sort of thing.

I also think that we should strongly consider the satellite clinics in northern California area. I'm sure California is not unique in this sense. Many of the States probably have the same problem.

I'd like to remind you that California is third in size of all the 50 States and first in population. We have an approximate population of 10 million in northern California and 104,000 square miles. The satellite clinic is a very good idea, and I've heard you mention flying medical teams up north. That sounds good, the mobile unit would be good. They feel very alienated from the VA in northern California.

As Harry Walters says, we don't have problems. We only have challenges. This is a hell of a challenge, I'm sure. We do support the statement by the ex-POWs given earlier and might I suggest that they get a distinctive priority card for the hospitals. They do have problems with clerks and this sort of thing, understanding their problems. I'd like to support that.

I'd like to support the move to domiciliaries, nursing home care for the aging veteran, and the support for State homes which I'm sure Paul Battisti will address later.

I'd like to thank you all for this opportunity and thank you for holding the record open.

Mr. EDGAR. Thank you very much. All three of your statements are really very, very clear and you raise some issues that we hope to raise with each of the medical directors and the regional administrator when they testify. I have no questions at this time.

I yield to my colleague, John Paul.

Mr. HAMMERSCHMIDT. Well, I have no questions except Mr. Goldman made a statement I wanted to comment on.

Mr. Goldman, the House Veterans' Affairs Committee is not ever going to let anybody dismantle the VA hospital system. I want to assure you of that.

Mr. EDGAR. Any other comments?

Mr. GOLDMAN. We do need their reassurance with the Grace Commission report.

Mr. EDGAR. Well, we have all read the preliminary report that was not accepted by either the administration or by our committee. As long as we have support within the top level of the VA and Harry Walters and the bipartisan support that we have on this committee, I can assure you that we will not mainstream, which is the issue that you and the national veterans' organizations are concerned about, the mainstreaming of the veterans' health care system into the private system.

I would caution you a little bit to learn the distinction between the word "mainstreaming" and the word "sharing," because while all of us on the committee are committed very strongly not to mainstreaming the system, there are in rural areas a great deal of possibilities for sharing. For example, if we had an $8 to $10 million veterans' clinic that we could establish next to a community hospital in a rural area which does not have the advantages of a Palo Alto or a San Francisco Veterans' Hospital, but does have a small community hospital, we could put two or three staff physicians from the VA at that facility to do clinic services. We might be able to have a shared relationship with the veterans getting quality care for outpatient service and then go into the regular VA services hospitals for their acute care facilities.

In the Florida area, this is being looked upon in Congressman Mike Bilirakis' district where they are simply too far away from the traditional veterans' hospital. I think we're going to have to look at some shared relationships in areas where, between now and the year 1990, we simply won't be able to put, or the demographics are such that we won't be able to put an adequate facility in place. Yet we still want to provide for that veteran.

Another area of shared relationship is in the whole area of community health services where we can share some responsibility to those veterans who are in their homes who need certain nursing services and other services.

So you're right on target about not mainstreaming and I think the chairman of the full committee has really focused that. I'm not playing games with you with the word difference. I'm simply saying if we're going to be creative in providing health care in the future, we're going to have to be innovative. We're going to have to say to the private sector: "Your services are not as adequate as the veterans' health care service. Your quality of care is not as good as our quality of care." We're going to have to be out on the cutting edge with our research and with our delivery of services that puts us second to none. I can assure you that the members of this committee do not support in any way the Grace Commission preliminary recommendations.

Mr. GOLDMAN. Sir, you hit the right idea when you said "playing semantics" or "playing words" with me. I look for that mainstreaming or sharing to mean the same thing. I point out a statement that was made by one of the prior speakers when the schools

have taken over, or come in to the VA and have taken up the priority of space. Where the attitude toward the veteran has been cold and calculating and certainly unemotional or involved.

I certainly concur with the fact that the Arizona veterans, and I'd much rather see a mobile unit come around that says veterans' care—not mainstreaming, not sharing. I don't believe that the sharing is there unless it's a major concern to a particular medical condition.

When you're talking about normal medical care, I'd much rather have it on a roving basis, on a regular roving basis, than I would to be with mainstream and/or sharing. I don't think there's a hill of beans between the two words. Ultimately what's going to happen is the sharing is going to become a greater share to the other side, and we're going to slowly be merged into that community hospital. Because as the need and as the empathy and as the sympathy starts to die away with the years as they go on, as is evident from the time of Korea or Vietnam to now, we start to lose that, and that's what my concern is.

Mr. EDGAR. Mr. Goldman, you and I disagree on that issue. If you needed the services of a CAT scanner today, and the Veterans' Hospital in Erie, Pa., does not have that CAT scanner to provide that service to you, they'd have to find somebody in the neighborhood, in the area that had that facility to save your life. And they would share that responsibility. It would be the VA's primary responsibility to make sure that facility was provided to you and that the best quality care was given.

I've got to say to you that if the medical director of that hospital were to say, "I'm sorry, Mr. Goldman, we're not going to give you that adequate care because we'd have to borrow it from another facility," I have a suspicion that you would say at that point, well, wait a minute, maybe we ought to take a second look at this in terms of shared relationship. I think you're wrong in terms of thinking that this Member from Pennsylvania believes in any way that we ought to mainstream.

We share with the Navy here in this area certain critical care facilities that we have. We share research facilities with the medical facilities in the area. I've got to say from my analysis—and I know you and I disagree on this—the quality of the veterans' health care is higher because of those shared relationships. We won two Nobel Prizes in the last several years because of our research capabilities. None of those capabilities would have been possible had we not shared the technical skills and education of the academic communities in the area.

I don't want to prolong this. I respect your point of view. I simply think that you haven't carefully evaluated my point of view.

Mr. GOLDMAN. Let me just cite another example. You talk about this CAT scanner, and as long as you brought up that specific example, the Kaiser Hospitals in southern California and in northern California use a mobile unit for CAT scans in particular. They do not put one in each and every one of their hospitals, just as a point.

So if that veteran needed that, where it is possible, we'd like to have it. Where it is becoming critical and a major cause of medical

care, then I think it's important that he do get wherever—wherever he can get it.

Mr. EDGAR. I thank the gentleman for his comments. I have no further questions.

Any additional questions?

Thank you. Our next witness will be the administrator of the Veterans' Home of California and representing the Department of Veterans Affairs, State of California, Mr. Paul Battisti.

Mr. Battisti, we appreciate your patience with us today. We are very pleased that yesterday the President signed the Veterans' Health Care legislation; putting in place the 4-year extension of the Vet Centers, the womens' advisory board, and studies on post-traumatic stress disorder and atomic veterans. This new law also included a major provision changing the per diem rates for State veterans' homes. This committee listened very carefully to the need for such an increase and visited several of the State homes. It is my opinion that the most economical way in which we can provide a veteran quality care is a partnership between the State and Federal governments. We want to say right off the bat that we are very committed to that.

This committee wrote that legislation and insisted in the Senate that they keep our numbers at least as high as possible to provide the per diem rates for State veterans' homes. Your full statement will be made a part of the record and we invite you to share it at this time.

STATEMENT OF PAUL BATTISTI, ADMINISTRATOR, THE VETERANS HOME OF CALIFORNIA, AND REPRESENTING THE DEPARTMENT OF VETERANS AFFAIRS, STATE OF CALIFORNIA

Mr. BATTISTI. I'm delighted to hear that news, Mr. Chairman. We knew that it had been proposed by the House and certainly having been past president of the National Association of State Veterans' Homes, I know that we have the support of the Veterans' Affairs Committee and the House.

Andy Mendez, who was supposed to be here today is the Director of the Department of Veterans' Affairs appointed by the Governor. He is not here because his wife is ready to deliver, and he had a choice to make as to whether to suffer the displeasure of this committee or to suffer the displeasure of Mrs. Mendez. I think you will agree he made a wise choice.

Mr. Chairman, I have a very brief statement to make. Members of the committee, I'm Paul Battisti, Administrator of Veterans' Home of California, representing the California Department of Veterans' Affairs.

The Department of Veterans' Affairs is responsible for programs in veterans' services, farm and home loans, and long-term residential and health care. It's my understanding that this will be the first representative of a State home that you've heard in the course of your hearings around the country.

The Veterans' Home of California is a 1,550 bed facility located at Yountville in the Napa Valley, about 50 miles north of San Francisco. The home cares for an average of about 1,400 veterans in five levels of care—from acute to independent living.

The average age of the members of this community is 74 years. Our population includes veterans from World War I through the Vietman conflict. We have 52 veterans from the Vietnam conflict. We accommodate women veterans, 134 of them. And we have a unique program for couples including nonveteran spouses.

Ours is primarily a geriatric facility. We appreciate your invitation to testify at this hearing because, as 1 of 49 such facilities nationwide, we represent a significant resource in meeting the long-term care needs of our Nation's veterans.

Further, as stated in the General Accounting Office Report, 82-7, of October 22, 1981, the State homes are a cost-effective alternative in providing care in VA facilities. Now, this is not to say that we can or should be an alternative to VA care, but rather that the State facilities offer a cost-effective partnership with the VA in helping to meet the long range needs for total health care of the Nation's veterans.

As partners, the VA and State homes should seek ways for more effective joint planning, cost sharing, cooperative programs for education and research, and for the sharing of talent and expertise.

The Veterans' Home of California will celebrate its centennial in 1984. It's enjoyed a distinguished record of service to veterans in good times and in bad. Today we are on the threshhold of a renaissance which will modernize, replace, or renovate all of our buildings to meet current State and Federal fire, life safety and environmental codes.

We're relying on the VA's 65 percent grants program to complement the legislature's endorsement of this $40 million master plan. In the last 5 years, the State has demonstrated its commitment to quality care at the Veterans' Home with a 25-percent increase in staffing and a 100-percent increase in total budget.

We urge the Veterans' Affairs Committee of the House of Representatives and its Subcommittee on Hospitals and Health Care to view the State home programs as a valued and competent partner in delivering health care to veterans.

The VA could well profit from a positive, supportive and cooperative relationship with the State homes with a resulting beneficial effect on the veterans we're dedicated to serve.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Battisti appears on p. 112.]

Mr. EDGAR. Thank you very much for that statement.

Before yielding to my colleague from Ohio, I'd like to just echo your sentiments and your statement. For those in the audience who may not be aware, the Federal Government 8 years ago decided to get into the issue of State homes and support them with a 65-percent commitment to construct and rehabilitate these homes with a 35-percent State share in the construction and rehabilitation.

In terms of per diem rate, we initially started out with a 30-percent Federal share and a 70-percent State and local share with a day-to-day care of the veterans. Up until recently, that had slipped because of inflation down to about 20-percent level.

Particularly in the area of nursing home care, we believe that there are ways in which many States can help us at the Federal Government, with tight budgets, to develop State homes and

expand them. We want to commend you for your work in that area.

Let me yield to my colleague.

Ms. KAPTUR. Thank you, Mr. Chairman.

Mr. Battisti, I really enjoyed your testimony and I wanted to ask you: What is your waiting list of applicants for your State nursing home?

Mr. BATTISTI. Up until about 6 months ago, we were able to accommodate all applicants within a space of about 3 to 6 weeks. Bearing in mind that we only admit directly because of limitation of beds, we only admit directly to domiciliary care and intermediate care. We do not admit directly from outside to skilled nursing or to acute care. Those beds are reserved for the occupants, for other members of the home.

So, considering the fact that we're only admitting directly from outside to about 800 of our beds, 3 to 6 weeks did not seem unreasonable. However, there's been an influx of applications in the last 7 or 8 months. We now have 96 applications totally processed, determined eligible medically and legally, awaiting admission. We think it's going to be anywhere from 3 months to 6 months before we can accommodate them.

Ms. KAPTUR. Could you repeat for me the type of the individuals who are applying for your facility in terms of their physical condition and economic circumstances?

Mr. BATTISTI. Most of the applicants for admission to the veterans' homes do have economic reasons for wanting admission. They are disabled. Because the eligibility requirements for admission to the State Home of California is first of all they must be disabled; and second they must be wartime veterans; and third they must have been residents of the State of California for 5 years.

To respond to your question directly, the type of conditions that the people who are awaiting admission have are disability, social and economic conditions, and a need for that kind of care.

Mr. EDGAR. Would the gentlewoman yield?

Ms. KAPTUR. Yes, Mr. Chairman.

Mr. EDGAR. Being an easterner, I wasn't sure that anybody lived in California for 5 years. I guess there are people who are even natives of California; is that true?

Mr. BATTISTI. Yes, sir. In fact, there's a grand organization called the Sons of the Golden West.

Mr. EDGAR. I yield back.

Ms. KAPTUR. Thank you, Mr. Chairman.

I also want to ask, you mentioned your innovative couples' program. Would you describe that briefly in more detail?

Mr. BATTISTI. Yes. In 1977, by action of the Department of Veterans' Affairs and legal—or legislative action within the legislature, the Veterans' Home was allowed to accept for the first time in the history of the home couples where one of them at least is capable physically of taking care of the other person in the family.

You can understand readily why that legislation traveled so fast through the assembly and the senate in the California legislature that it set some kind of a record.

Unfortunately, we can only accommodate at this point in time 16 couples.

Ms. KAPTUR. Thank you, Mr. Chairman.

Mr. EDGAR. Are there additional questions?

Mr. PENNY. Mr. Chairman, I want to find out if you have been authorized to receive matching grants from the Federal Government for your renovation program?

Mr. BATTISTI. We have applied for $25 million worth of grants involving 13 separate projects which are now a matter of record in the Veterans' Administration.

Unfortunately we heard today that there is a backlog of $72 million worth of grant requests and we're concerned about whether the Federal appropriations will keep pace with the needs, at least in the State of California.

Mr. EDGAR. Would the gentleman yield at that point?

Just for the record, Congressman "Sonny" Montgomery and myself have both written to the Office of Management and Budget and the VA urging them to dislodge that $72 million of backlog. We think that it's inappropriate for the Federal Government to freeze those funds at this point.

Mr. PENNY. So you come in behind that $72 million, or are you part of it?

Mr. BATTISTI. We are a part of it. I don't know at this point in time exactly where our 13 projects stand in relation to all of the projects that are still pending.

Mr. PENNY. Is the State waiting for the matching funds before it moves ahead with each one of those renovation projects?

Mr. BATTISTI. Unfortunately you have put your finger on one of the main problems with that program. We're caught in a catch-22 situation. The State says to us, we will commit our 35 percent when the Federal Government commits its 65 percent.

The Federal Government says, we will commit our 65 percent when the State commits its 35 percent.

Mr. PENNY. How much lead time will you be able to give the State once the Federal Government notifies you that money is on its way?

Mr. BATTISTI. The State is ahead of the Federal Government in the sense that our master plan is already in place, has been approved in principal by the legislature, and our projects have gone in on the plan phase basis right through 1990.

Mr. PENNY. But they will not release the funds until the Federal Government releases the funds. They have approved the projects but will not release the funds until Federal dollars are on their way.

Mr. BATTISTI. They have approved the commitment to bring that facility totally up to code. They are on an annual appropriation basis as is the Federal Government. And so they are not able to commit beyond year to year appropriations.

Mr. EDGAR. I yield to my colleague from Arkansas.

Mr. HAMMERSCHMIDT. If my memory serves correctly, we only appropriate $17 or $18 million a year.

Mr. BATTISTI. $18 million this year.

Mr. HAMMERSCHMIDT. Yes. We've talked with the VA about the need, because we think it's one of the best bargains around in VA housing. We're going to continue to try to promote an increase in

that because we just think the taxpayer gets more back on that than he does in nearly any other housing building.

Mr. EDGAR. I yield to my colleague from Ohio.

Ms. KAPTUR. I just have two quick follow-ups.

Is this the only veterans' home in California? You have one?

Mr. BATTISTI. Yes, it is.

Ms. KAPTUR. All right. To what do you attribute the 96 applicants you said have come in at influx, why do you think they have come in?

Mr. BATTISTI. I think the VA has very accurately predicted, on the basis of population trends and on the basis of age, the beginning of what we're going to see as a growing need for our type facilities. I think we're in 1983 and we're projecting that by 1995 we're going to be doubling the population over 65 years of age. Those are primarily the people that we're there to accommodate.

Mr. EDGAR. Just one final comment. The State of Pennsylvania presently has two homes and we visited other States that have a number of homes. Is there reason why you in the State of California have decided, as large as you are, only to commit yourself to one home as opposed to perhaps three or four smaller, regionally located State veterans homes which would get access to the same funds. The projects would make the same kind of percentage commitments, but would give the veteran a little more access to their local communities.

Mr. BATTISTI. Mr. Edgar, Assemblyman Klugh from southern California introduced a resolution in the assembly this year called ACR-42 that proposed that a feasibility study be done to establish whether or not there should be a second veterans home in southern California.

I testified this morning before the Assembly Select Committee for Veterans' Affairs in Palm Springs at which time I pointed out that the Department of Veterans' Affairs has accepted the responsibility for this feasibility study. I have been appointed to conduct the feasibility study and to submit a report by January of 1985 concerning that subject.

Mr. EDGAR. Thank you very much. I have no further questions. We appreciate your testimony here today.

Our final panel of witnesses is the group of people who are the directors of the medical centers in this region, headed by Mr. Daniel E. Cooney, Director, Western Medical Region, Veterans' Administration.

If he would come forward with his colleagues. Let me apologize for the time pressure and apologize for the impact that we've made on several of your veterans' hospitals over the course of the last 2 days.

We deliberately have chosen a style of going out and seeing the veterans' hospitals before we have the hearings so that we can better ask questions as well as have opportunities to talk to many of you privately. This gives us a chance informally and off the record to share our views and our ideas and our concerns.

It is important for us to hear your point of view and your concerns. Each of you have an opportunity to provide statements for the record. If you have them, I'd like you to include them.

I'd like to now turn to Mr. Cooney for his opening statement.

STATEMENT OF DANIEL E. COONEY, DIRECTOR, WESTERN MEDICAL REGION, VETERANS' ADMINISTRATION

Mr. COONEY. Thank you, Mr. Chairman and members of the subcommittee. My name is Daniel E. Cooney. I'm the director of the western region of the Department of Medicine and Surgery, Veterans' Administration.

I'm joined at the table with my colleagues from Medical District 27. Starting at my far right: Dr. Larry Foye from San Francisco VA Medical Center; Mr. Marvin O'Rear from the Livermore VA Medical Center; Harry Potter from the Reno, Nevada VA Medical Center; Clarence Nixon from Martinez VA Medical Center; Joe Mason from the Fresno VA Medical Center; and Jim DeNiro from the Palo Alto VA Medical Center.

Mr. EDGAR. Without objection, the full text of your statement is made a part of the record.

Mr. COONEY. Thank you. I would just like to point out that the problems and issues that we deal with throughout the western region can be further illustrated by focusing on one of its medical districts, district 27, which you are presently visiting.

Mr. EDGAR. Thank you, Mr. Cooney.

Mr. COONEY. I would agree with Congressman Hammerschmidt in his comment concerning the relative success that the VA health care budget has enjoyed in recent Congressional budgets. However, I would like to point out that the amount of money that the VA has been granted through the budget process has not been adequate to maintain our budget base.

We have been budgeted at an increase of approximately four percent over the last few years, while inflation has eaten into that at a rate—a certainly increased rate. So in effect what has been intended, I think, by Congress to be a hold-even budget has in effect been a declining budget within the VA health care sector.

[The prepared statement of Mr. Cooney appears on p. 114.]

Mr. EDGAR. Thank you. Do any of you have a response or reaction to either our visits to the few hospitals we have been able to visit and the questions we asked there, or the questions that were raised in previous testimony? Does anybody want to jump in and share something or get something off their mind that has been troubling them, or a concern they would like to raise? Mr. O'Rear?

STATEMENT OF MARVIN O'REAR, DIRECTOR , VA MEDICAL CENTER, LIVERMORE, CALIF.

Mr. O'REAR. Thank you, Mr. Chairman. I don't have anything to get off my mind that's negative. I'd like to reiterate a couple of things for the record which were stated to you and your colleagues yesterday.

The extreme pleasure and morale booster your visit to our medical center provided was widespread. The other comments I have made in the prepared statement. I have already distributed it, and in view of the time, I won't take the time to read those.

[The prepared statement of Mr. O'Rear appears on p. 125.]

Mr. EDGAR. Thank you. Your full statement will be made a part of the record.

We're very serious about our attempts to work in December, January, February and throughout the next couple of years in developing a strategy for the future. We're very serious about trying to get information, not just from medical directors and chiefs of staff, but from some of the people who you work with on a day-to-day basis who have innovative and creative ideas.

We were very pleased with the innovation that we've seen in this region. We were pleased with some of the things that we learned, some of the research that is going on throughout the area, some of the quality of care that is being provided.

But we also know that the bottom line is resources: How many dollars do we have to commit to the future? What kind of pressure the aging veteran is going to place on the system? How do we provide health care in non-institutional settings? How do we share relationships—maybe that's a bad word—how do we have a partnership with other institutions in the area to provide care?

We will hold the record open for a little while, and if each of you want to go back to your staffs and put together a 2 to 4 page document of your ideas for innovation in health technology and health planning for the future, we would really appreciate it.[1] It's our opinion, particularly my opinion, that the veterans' health care system really has to be on the cutting edge. It cannot allow itself to be dulled, or allow its institutions to be obsolete, or allow its staff professionals not to be of the highest quality. We need to continually look at ways to provide that health care in new ways.

We are the largest health care system in the world in terms of the number of hospitals and number of staff people that we have interlinked in this hospital network and we hope that you can help us with that. Now, does anyone else on the panel of directors have a statement they'd like to make or a question they'd like to ask?

Mr. MASON. Yes, if I may, Congressman.

Mr. EDGAR. Mr. Mason, will you identify yourself and your hospital.

STATEMENT OF JOSEPH J. MASON, DIRECTOR, VA MEDICAL CENTER, FRESNO, CALIF.

Mr. MASON. I'm the Director at Fresno, and I trust all goes well in the City of Brotherly Love since I left you there about 3½ years ago. And I do hope that the——

Mr. EDGAR. We could have done a little better with the Eagles but you know, we do the best we can.

Mr. MASON. I do hope the 76er's don't embarrass me during their season like the Eagles have so far.

I feel that it would be appropriate to quickly respond to my friend Art Kruse and what he had to say about the medical school affiliation within the VA.

If I might, I'd like to also take just a second to introduce two other friends and fellow veterans that have joined me here from Fresno today. One is Art Johnson. He is the State Commander of AMVETS. He is a member of Congressman Chip Pashayan's Veterans' Advisory Committee, and he's been very helpful working with

[1] Not received at time of publication.

us in identifying problem areas within the hospital that we've been too thick-headed to see.

And the other one is another State Commander, Bob Sparks. Bob is the State commander of ex-POW's and he has been instrumental in helping us set up a POW program in our hospital that we're proud of and I think he is proud of also.

I've been with the VA for almost 35 years now. I've been director at four health care facilities, Tuscaloosa, Ala., Wadsworth in West Los Angeles, in Philadelphia, and now in Fresno. Three of those were teaching hospitals affiliated with good schools of medicine. I think those of you that know the history of the Department of Medicine and Surgery are well aware of what medical schools have done to make the VA medical hospital system first class. It has indeed been a two-way street. We've done a lot that's been very helpful to medical schools too.

But I think what Art is speaking toward is what you normally see when you go from a nonteaching to a teaching facility. Prior to 1976 Fresno was not affiliated. At that time, late in the year, they were able to affiliate with the University of California School of Medicine at San Francisco. At that time, the hospital had five or six physicians, I forget which, only one of them was board specialized.

We now have approximately 35 or 36 physicians, the vast majority are specialized, some subspecialized. As a result we have been able to greatly expand the range of services that we can provide locally. We no longer transfer many of the patients to the bay area that we did prior to the affiliation becoming active.

When you make that transition from nonteaching to teaching, you frequently see a lot of change in the activities of the medical center. It becomes a much more dynamic, hectic operation. We're busier each year than we were in previous years.

I think this can be misunderstood. When I arrived there 3½ years ago, or shortly after I arrived, we had some veterans that were actually picketing out in front of the hospital. They had issued a mandate to the President, and to all of you as members of the Oversight Committee in the House, stating that they would continue to picket the hospital until the President had dissolved the affiliation.

It did give us an opportunity to work with those individuals and to educate them. I think without exception all of those individuals now are very strong supporters of the medical school affiliation.

I hope Art will be kind enough to let me talk to him a little bit about some of the advantages we see. It isn't as bad as Art seems to think it is.

Mr. EDGAR. Let me yield to my colleague, Dan Mica.

Mr. MICA. Let me ask you before we leave you, Mr. Mason. Are you the Director of the facility that Mr. Kruse talked about?

Mr. MASON. Yes. He has cited that as an example of a general problem within the VA as he sees it.

Mr. MICA. Is that the facility where he had indicated there was a complete completion date of October of this year for the earthquake stabilization?

Mr. MASON. For December of this year. That's right. That is a seismic correction project, and it has been 2 years in duration. It is

on schedule. It has been terribly disruptive. It's the third one I've gone through but the first one I've gone through where they've used this method.

Mr. MICA. It will be done on schedule though?

Mr. MASON. It will be done on schedule and I agree with Art, it's been a tough thing to go through. But having been at San Fernando when it collapsed in the earthquake back in 1971 where we lost, as you know, 46 people, I do think it's a needed thing. Although it has been very disruptive. We are on schedule.

Mr. MICA. Thank you. Mr. Edgar. Mr. Potter.

STATEMENT OF HARRY C. POTTER, DIRECTOR, VA MEDICAL CENTER, RENO, NEV.

Mr. POTTER. I'm Harry Potter, Director at the VA Medical Center at Reno. I just have two quick comments.

First of all, I want to extend greetings to you from the veterans of our neighboring State to California, the State of Nevada, and a fast growing State, particularly in the Reno area. I think you are all aware of that. We're trying to meet the demands of the veterans in our area, and I think so far we're doing quite well.

The other thing I'd like to mention to back up and support Mr. Mason's comments, the impact of what we call newly emerging affiliations with medical schools. We have that situation in Reno. We're addressing it. We're getting support from our district and our region. We're grateful for that. The impact is growing greater as the demand grows greater and as the need to support our very active affiliation as the major teaching hospital for the University of Nevada Medical School. Thank you.

Mr. EDGAR. Thank you. Mr. Nixon.

STATEMENT OF CLARENCE H. NIXON, DIRECTOR, VA MEDICAL CENTER, MARTINEZ, CALIF.

Mr. NIXON. I'm Clarence Nixon, the Director at Martinez. I also welcome you and thank you for being here. I will echo what Joe has said and add only by way of comment, when I became the Director at Martinez in the mid-1970's, at a time when we were making a major effort in the VA to upgrade the quality of care there and to further prepare ourselves to provide care for the influx of northern Californians. It has been gratifying to join in a partnership with the University of California at Davis. The results of that effort speaks for itself. For approximately a year we have had a representative of the veterans' organizations on our deans' committee. He is here today. He is in the audience. His name is Jack Collier. He has held positions of high leadership in the VFW and the American Legion in California. He is retired from the Navy. He served as a county service officer and is now the supervisory service officer for the VFW of northern California. He served on our deans'committee and if you wish to question Jack, I'm sure that he can give you his own personal observations about the experience at Martinez and our affiliation with the University of California at Davis.

Mr. EDGAR. Thank you.

Dr. Foye.

STATEMENT OF DR. LAURANCE V. FOYE, JR., DIRECTOR, VA MEDICAL CENTER, SAN FRANCISCO, CALIF.

Dr. FOYE. I just want to thank the committee for this expression of sincere interest that they have displayed by visiting our facilities and as a District Director, I wish to thank you for coming to District 27 and seeing our facilities, a representative sample of them. I would like to comment on what I think is a major problem facing the Department of Medicine and Surgery.

Since 1978 the resource expansion in the Department of Medicine and Surgery has plateaued. From 1971 to 1978, there was a major growth of resources and a major growth of staffing for the Department of Medicine and Surgery and the change in the hospitals in the Nation, the VA's hospitals, and the services they could render were absolutely fantastic. Hospitals were not recognizable in the late 1970's if you had seen them in the early 1970's, the change was tremendous.

Since 1978 we've been on an essential plateau. It was produced primarily by a rapid inflation rate and a budget that did not keep up with that, and with a relatively stabilized staffing level. The demands upon us for services have not stabilized. We've had increasing demand for services at all of our facilities, and you know the increasing demand that is predicted or estimated based upon the aging veteran population.

We recently looked at 1,200 new applicants for care at our hospital, 65 percent of them had never received care at a VA hospital before or from the VA. Sixty-five percent had gotten their care under third-party carriers from their own resources, from other sources than the VA.

We are tapping a new population. We are experiencing a tremendously increasing demand of the aging population for both the acute and extended care, an increasing demand that we're having because of in-migration, an increasing demand that we are having because of the improvement in the complexity of care that must be provided. We must receive enough resources to keep up with modern medicine today and tomorrow.

Mr. EDGAR. Thank you.

Mr. DeNiro, do you have a comment.

STATEMENT OF JIM DeNIRO, DIRECTOR, VA MEDICAL CENTER, PALO ALTO, CALIF.

Mr. DENIRO. Just a short one. Jim DeNiro, Director at Palo Alto. We appreciate very much your visit to Palo Alto and I think you can get a feel for where the future is and what's on the cutting edge of medicine. The support and backing you give us is very much appreciated within the staff and they are very impressed with your interest.

Mr. EDGAR. Thank you. John Paul?

Mr. HAMMERSCHMIDT. Mr. Chairman, I have 17 questions that I want to ask; but because of the time I'm not going to do that here verbally. But I would ask that I be allowed to submit those to Mr. Cooney and let them respond for the record.[1]

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[1] See p. 128.

I do have one or two I'd like to ask right now verbally, Mr. Chairman.

Mr. EDGAR. Without objection, all members will be permitted to direct written questions to the witnesses in the next couple of days.

Mr. HAMMERSCHMIDT. Mr. Cooney, what has been your experience with the new law giving priority medical care to exprisoners of war and providing special medical examinations for them? Are the VA employees completely up to date on this subject?

And let me ask another question along with it. We sometimes hear that some hospitals are not completely up to date on the VA policy with respect to agent orange examinations and treatment. We are told there is a lack of concern, that sometime it is evident that while the Central Office policy is a good one it isn't always properly administered. Would you please comment as to this medical district? Do you feel that your people are communicating well with those who are being examined, both the POW question and the agent orange question?

Mr. COONEY. Yes, sir. I think that both the issues that you mentioned—and I'm not begging the questions, I'll respond directly to the questions, but it points out a bigger issue, I think. There have been a series of new programs initiated by legislative action that involve additional work for the staff of the VA hospitals, and very few of those changes in requirements have carried with them any additional resources.

So as a result, what we are doing is asking our already overworked relatively low-paid clerical staff to assume a great deal of additional responsibility and effort. We are making a number of efforts to insure that they are adequately trained and prepared.

However, I'm afraid that some of the problems, particularly the prisoner of war issue, is a question of the employees reaching a saturation point in terms of the amount of additional workload they can absorb. I think that is the overriding issue. I think that we are making a great deal of effort. We have done over 165 POW examinations in this medical district in the last 5 months. The VA has started a tracking program as of October 1 to insure that adequate records are maintained.

Each medical center has a prisoner-of-war coordinator appointed. I think that a great deal of effort is being done, a great deal of training is being done by the coordinators.

Specifically in the prisoner-of-war issue in order to minimize the impact and to use sort of a fan-out process, each medical district has been asked to appoint a senior coordinator for the POW program. That person receives training, comes back to the medical district, works with a representative of each medical center to train that person in the process. That person then is expected to carry the training forward to the staff of the hospital. This obviously takes some time.

I think that the implementation is in process, but it probably has not kept pace with the expectations perhaps in some areas of the prisoners of war.

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Mr. HAMMERSCHMIDT. Well, I would say, Mr. Cooney, this isn't the first district where we've heard this complaint. Of course now you have some different forms, some newer forms, and maybe that will help straighten out the system.

I'm sure that you heard Mr. Brady's comments and his companion's comments, and I'm sure that you are sensitive to what those comments were.

Mr. COONEY. We definitely shared his concern; yes, sir.

Mr. HAMMERSCHMIDT. A recent report by an association of orthopedic surgeons was very critical of the VA. The report said, among other things, that equipment often broke down during surgery, funding for orthopedics was not properly allocated, surgery was often delayed and the patients stayed too long in the hospitals.

I wonder if you could please comment in terms of this medical district and this medical region.

Mr. COONEY. Well, I know of no case where patient care was in any way jeopardized anywhere in this region in regard to equipment failure. There has been a large increased demand for orthopedic surgery, which I presume is consistent with the aging population that we serve. I think we find that to be particularly true in case of hip replacements and other joint replacements which are very time consuming in terms of orthopedic surgeons' time and very expensive in terms of the prosthesis that's installed.

There has been a continuing increase in this district. For example, there is an increase from 1982 to 1983 of about 5 percent in orthopedic cases. In other districts within this region, the increase is even greater.

There is probably a backlog, and perhaps the medical center directors could address that specifically because there is an increased demand for this type of surgery. I know of no case of a compromise in the quality of care as a result of that backlog however.

Mr. HAMMERSCHMIDT. Well, any director that would like to comment, if he has a problem, we'd like to know about it.

Just one more question, Mr. Cooney.

Mr. COONEY. Yes, sir.

Mr. HAMMERSCHMIDT. You commented on the budget. I know that you're 16 percent over your estimates as to workload in this region. How are you coping with the obvious budgetary concerns that these figures represent?

Mr. COONEY. Well, there's a number of activities that take place. Primarily I think that the individual medical centers have to constantly be looking at their priorities. They have to constantly be looking at programs that are less productive and decreasing the emphasis on those programs to increase the emphasis on the demand that workload is creating.

The vast majority of our individual medical center budgets are in personal services and employment costs. They are constantly having to look at vacancies, reallocate vacancies to more critical areas to keep the work force as much as they can on the point of the workload. And that, generally speaking, has been in the outpatient area. We have experienced a vast increase in outpatient activity in this district and in this region and in DM&S in general with, to be quite honest, very little in the way of commensurate funding for those programs.

All medical centers are increasing their activity in the outpatient areas and they have had to shift emphasis from inpatient programs, reallocate resources to meet that need.

Mr. HAMMERSCHMIDT. Let me say while I have the mike that it's been a real pleasure being with you, Mr. Cooney, and with your directors. We didn't have an opportunity to get to all the hospitals. Of course, Mr. Mason, Mr. Potter, and Mr. Nixon, we appreciate you being here today.

Just for the benefit of the audience, we've talked at length with these gentlemen off the record about nearly every subject you could imagine. We think they've been very responsive. We appreciate your cooperation.

Mr. COONEY. Thank you.

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

Mr. EDGAR. Thank you. Dan Mica?

Mr. MICA. I would just like to second, if I may, what John Paul Hammerschmidt has just said. First, I'm 3,000, 4,000 miles from home, so I'm not going to gain anything by this, but we have visited with veterans' people and their representatives throughout this country, and they come to Washington, and I see a lot of problems and I have no hesitation to sit up with the power of a Congressman on the committee and say you're dead wrong and I think you're doing a lousy job.

But in this case, I think that from what I've seen, California can be a model for the United States. I'm very proud of what I've seen here. You fellows are doing a great job. I wish we had a little more of this in Florida. I hope that we can do a better job because the only thing that I think you need is a little more money. You've got the enthusiasm, the knowledge, the professionalism and the ability, and I think you're doing an excellent job.

And I might just add while I'm on that, Chairman Edgar, and our ranking member, John Paul Hammerschmidt, have taken the time, for the first time, and I've been around the Congress now 17 years, in and out, to go across this country and say "What do you need, tell us, because whether you like it or not, this is the committee and this is where the money requests start in the United States for medical care in the veterans' system. Our committee, with our freshman members and all of us, has a greater understanding of your needs, and can present them and present them better to our other colleagues on the committee and the Congress. I think we'll all be the better for it.

So I appreciate it. I commend you. And I commend our chairman and our ranking member. Thank you.

Mr. EDGAR. Thank you. Marcy Kaptur.

Ms. KAPTUR. I notice in your testimony that you didn't mention the number of satellite clinics that exist in the region. Is that just——

Mr. COONEY. I did not mention it in my remarks. It is in the text of my remarks, of my comments.

Ms. KAPTUR. It's in the text?

Mr. COONEY. Yes. For this district, yes.

Ms. KAPTUR. Could you——

Mr. COONEY. It's written in indelible ink. Invisible ink. I apologize.

Ms. KAPTUR. What number is it?

Mr. COONEY. Well, we have satellite clinics attached to the Oakland and Sacramento medical centers. We have a mental health clinic in San Jose. One in Berkeley. And of course the Hawaii and Manila clinics which are really not true satellite clinics because they are attached to——

Ms. KAPTUR. Right. You listed those as independent outpatient clinics. I'm trying to gain an understanding in this region of the country of what the distinction is in your minds between independent outpatient clinics and satellite clinics. I would appreciate any——

Mr. COONEY. The basic difference is an independent outpatient clinic is under separate management. The satellite clinic is attached to a medical center for management and logistics purposes.

Ms. KAPTUR. For those clinics that you have that are independent, what was the reason, the underlying reason for their establishment?

Mr. COONEY. I would assume it was to meet a workload in an area that was not served by a VA medical center which did not have a VA medical center in close proximity to provide the support and supervision that would be required by a satellite clinic.

Ms. KAPTUR. I read that you have independent outpatient clinics in Hawaii and Manila, but I didn't in the testimony find where the third one was.

Mr. COONEY. Those are the only two independent outpatient clinics in this medical district. The other are satellite clinics attached to a medical center.

Ms. KAPTUR. The testimony reads, "Three independent outpatient clinics within this area."

Mr. COONEY. Perhaps that's an oversight or a misprint.

Ms. KAPTUR. Thank you very much, Mr. Chairman.

Mr. EDGAR. It's in the region.

Mr. COONEY. In the region, within the Western region we have three independent outpatient clinics. I'm sorry, I thought you said district.

We have independent outpatient clinics in Los Angeles, in Los Vegas and in El Paso, Tex.

Ms. KAPTUR. And basically because in those areas there is not a VA—a major VA——

Mr. COONEY. They are either geographically removed or the workload is so large that it requires separate management which would be the case in Los Angeles.

Ms. KAPTUR. Thank you very much.

Mr. COONEY. I'm sorry I misunderstood your question.

Mr. EDGAR. Congressman Penny?

Mr. PENNY. I don't have any questions. I do appreciate though the time that many of these gentlemen have given us over the last couple of days and their willingness to stay here through long after the testimony. I know that we've benefited from the testimony presented to us by the veterans in this region and trust that their advice and suggestions will be helpful to you as you continue to try to serve veterans' needs in this area of the Nation.

Mr. EDGAR. If I could indulge in your patience just a little longer, I'd like to call on Dr. Miller, who is the assistant regional manager

of the readjustment counseling program of the Western region for his statement. And Dr. Miller, your full text will be made a part of the record.

And then I'd like to make final comments to all of you and if you have any additional comments you would like to make I'd like to hear it as well.

Dr. Miller, thank you for your patience. The last shall be first and the first last. We'll try to take your testimony.

Dr. MILLER. I don't have a prepared text right now. And I would also like to request that the record be kept open——

Mr. EDGAR. Without objection, it will be made a part of the record when it is received.[1]

STATEMENT OF DR. MICHAEL MILLER, ASSISTANT REGIONAL MANAGER, READJUSTMENT COUNSELING PROGRAM, WESTERN REGION, VETERANS' ADMINISTRATION

Dr. MILLER. Thank you. I guess I'm in an unusual position coming here because we need to thank you for the resources that you have provided over the next 4 years, through 1988, for the Vietnam veteran and the readjustment counseling service. I was very happy to hear that the President had signed that bill along with the other provisions.

I think one thing that I would like to point out is that the readjustment counseling services that originally began exclusively for Vietnam veterans' and had a lot of political overtones, have widened their scope. Many people from the World War II generation and from the Korean generation have also come into our vet centers for the purpose of receiving referral services.

In addition, we've also just recently been seeing an influx of people who are service retirees. That is, they spent their full 20 years and now leave the service, and within 1 to 2 years find themselves having some or most of the symptoms that are commonly associated with post-traumatic stress disorder, and find our referral services very helpful for them too.

We have in fact seen two in this area, and I saw one in Boise. Lebanese veterans, Marines who were in Lebanon who lost people, who came back, one was here at Madigan and I met him in Boise on an airplane. He went to the vet center there. So I think the readjustment concept is becoming much more generic as we discussed back in April about post-traumatic stress disorder.

And that means the VA really truly is on the cutting edge because this traumatic disorder is not exclusive to combat, but has a very similar presentation in civilian disasters. It is the experience that we're gaining working with the veterans, the combat veterans, that is helping us help people across the community.

In addition, I want to say that the outreach services do operate in the community. These gentlemen here in this region—Mr. Cooney especially—have been very helpful working with our outreach centers in cooperation and providing medical services and providing the supports that were necessary.

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[1] Not received at time of publication.

It is important these services remain out in the community, I believe, so that the people can walk in and receive them almost immediately. Many of the complaints that we heard from other veterans about the long lines, we never seem to find in the outreach centers because they are out in the community and we're open.

I do have to say though, not to look a gift horse in the mouth, is that we have prepared an expansion plan to reach those outlying areas where veterans can get to them. It has been presented to Mr. Walters.

Mr. Walters, when he traveled around here, mentioned that the Vietnam veteran will be taxing the resources even more because, by 1991, by Mr. Walters' understanding, the actuarial tables say that the Vietnam veteran will become the majority veteran within the VA. And despite the fact we've always emphasized the youth of the Vietnam veteran and the problems that he had, in fact the average age of the Vietnam veteran now is over 34 years of age. By 1991, when they receive the majority status in terms of numbers, they will be 41 years of age on the average. That's the beginning of the medical problems.

So I'm afraid that we also are going to contribute to the load that the VA is going to have to carry in the future. Thank you.

Mr. EDGAR. Dr. Miller, as always we appreciate your outstanding leadership in that whole area. We did a magic miracle at Washington. As you know, the bill that Lane Evans introduced was for 3 additional years of readjustment counseling and, on a bipartisan basis, got that past the House. We found the Senate only wanted 1 year. We thought that was stingy, but we went to them in conference and we convinced them, I think, simply by the way in which the vet center program has matured, has begun to impact in an important way, and is seeing more veterans, not just to half the two provisions and come out with a two-year extension, but in fact to add the 1 year of the Senate and, in the most unusual legislative procedure I've ever seen, we agreed to a 4-year extension of the readjustment counseling centers.

It's not just helpful to the veteran. It's helpful to the staff to have that stability and we're looking at ways in other parts of the health care system to develop that stable process.

Let me say to all of you that in the 2½ days that I've been here in California—and this is my first visit ever to San Francisco—there are two words that pop up as reflection of my visits to the hospitals. The first word is the word excitement. When I saw the excitement of the researchers at Palo Alto who were interested in the concept of regenerating the tissues to try to help spinal cord injury, or to talk to those who were working on research in the schizophrenic area, trying to develop a response, or to sit on that little wheelchair and move it around and see the excitement in the eyes of the staff working on it, or to watch a veteran with audio commands to a little magic arm develop a response, I not only felt the excitement, but the excitement was elicited from the researchers.

When we went over to Livermore and had lunch together, we listened with great interest to the passion that existed there for the possibility of developing a model for extended care for the elderly veteran.

And we picked that up in a couple of areas, also in Palo Alto with trying to help the families of veterans who need extended care. The excitement in the eyes of people talking in both those institutions was quite helpful.

Today when we were briefed at the San Francisco Hospital, there was a sense of excitement there, too, in terms of cancer research and in terms of the availability to use these facilities if there is an earthquake or some other catastrophe.

So I go away from my experience here with a real sense of excitement that the VA is on the cutting edge. The fact that you helped to invent the combat unit, which is the second step up from the outreach centers for those veterans who have served in combat who have psychiatric and other problems, the excitement that's there, I think, is really important.

The second word that I find as I crossed the Nation, but particularly here, is a sense of hope. In the midst of all the budget cuts, and in the midst of all the frustrations your staffs have had, personnel problems you try to struggle with, and the individual veteran's cases, there is a sense of hope.

John Paul has made a major contribution in all of our hearings by reminding us that we do spend almost $26 billion of the Federal budget trying to help veterans. We don't do everything right. We haven't in the past always handled the problems well. We have a lot of hospitals that were put in place after World War II or before that are simply obsolete, functionally obsolete, that need to be replaced. We have a number of innovative outreach centers that we've got to develop.

I feel a sense of hope that the Congress is listening. The bill that the President signed into law yesterday, the extension of the readjustment counseling centers, women's advisory board, increase in per diem rates for State veterans' homes, studies of post-traumatic stress disorder in Vietnam veterans, studies of atomic veterans, with the concurrence of Harry Walters and the VA and the President's signature, I think we've made some real statements this year that we are committed to this hope.

We're not going to solve the problems that we talked about overnight. It's not going to happen next year or the following year, that suddenly magic will come, and lots of dollars will flow, and all of these facilities will be created.

I'm hopeful that the challenge I laid out to you, and the challenge that we've accepted as our mission, to develop a 5-, 10-, 20-year strategy for the veterans' health care system, care for the needs of veterans of the ages and categories that we've talked to is a challenge that all of us have accepted.

I would hope that you would go back to your staffs and help to continue to stimulate that challenge. From the excitement that I heard from the people that we had a chance to talk to, I go back with also a sense of hope.

Let me thank my colleagues for their patience today. We had intended to spend 2 hours, we spent 4. You know, what's 2 hours among friends. We had intended to try to be briefer in our comments and try to coordinate a little better, but I think this has been well worth it. I would like to commend my colleagues for coming and taking the time out of their schedules. They could be

in their districts or they could be celebrating Thanksgiving, but they choose to be working on veterans' issues.

Thank you very much.

This hearing stands adjourned.

[Whereupon, at 6 p.m. the hearing was adjourned.]

APPENDIX

Statement of Senator Dennis DeConcini

First, I would like to commend Congressman Edgar for the field hearings which he, as Chairman of the House Veterans Affairs Subcommittee on Hospitals and Health Care, has held in each of the Veterans Administration Medical Districts over the past year to assess the quantity and quality of inpatient and outpatient medical care. The yeoman's task he undertook and the comprehensive manner in which the hearings have been conducted are illustrative of the conscientious way in which he approaches all his legislative responsibilities. The veterans of the Nation have a unique friend in Bob Edgar, and all of us who have a deep interest in veterans' health care are indebted to him for his efforts. The information gathered from the field hearings will provide the members of the House and Senate Veterans' Affairs Committees with reliable information upon which to make sound decisions regarding the future of the VA medical system.

I sincerely regret that I was unable to personally participate in the hearing held in San Francisco on November 22, but am pleased that the interests of Arizona veterans were ably represented in the persons of Lou Blakely and Dick Countryman. I also appreciate the opportunity to submit a statement for the record.

During my first two years as a member of the Senate Veterans' Affairs Committee, I received numerous complaints from veterans about long delays in scheduling for appointments, for necessary surgery and for the filling of prescriptions. I had also been informed that whole units of our hospitals had to be

closed due to nursing shortages and that the lack of nursing home beds had reached critical proportions. In order to crystallize the VA health care problems in my state and to work towards their resolution, I chaired a Senate Veterans' Affairs Committee field hearing in Phoenix, Arizona in January, 1982. The crux of all the problems aired at that hearing can be reduced to two words -- inadequate resources -- inadequate resources in terms of budgets and manpower.

I am pleased to report that we have made some progress over the past twenty months. An automated data processing system has been installed at the Phoenix VA Medical Center and a Computerized Axial Tomography (CAT) Scan will be functioning later this fiscal year. The clinical addition at Tucson is underway. The drawings for the surgical suite expansion at Prescott have been completed and the project should be offered for bid in February. And a contract was recently awarded for the preparation of preliminary plans for the 120-bed nursing home care unit at that facility. Finally, with the enactment of P.L. 96-330 and 97-251, Congress has taken the initial steps towards resolving the serious nursing recruitment and retention problems which have plagued the VA for a number of years. So, we have not been standing still, but the fundamental problem underscored in the testimony of the directors of the three Arizona VA Medical Canters -- that of increased patient load and inadequate resources to meet that demand -- has not been resolved.

Arizona's problems are largely the result of a burgeoning population. While the general veteran population has increased by 8.8% over the past decade, Arizona's veteran population has increased by close to 50%. And that dramatic increase is expected to continue throughout the remainder of the century. The general population in Arizona is projected to double by the year 2000, and the veteran population is expected to grow from the current level of 385,000 to 507,000. It is patently obvious that the physical plants at all three Arizona VA

Medical Centers will have to be expanded and staffing resources increased to meet the projected increase in patient load. An adequate construction budget is essential to insure that no eligible veteran is denied care in the years ahead. There is no room for politics in future planning. Planning decisions must not be delayed and they must be based on current and projected demographics. Resources will have to be allocated or reallocated to areas of greatest need.

One problem of particular concern to Arizona and other Sun Belt States is the increase in patient load during the winter months. Insufficient attention has been directed to this problem in the budgetary planning process. This problem must be addressed by Central Office so that our facilities will not be overtaxed by the snow bird population.

An adequate budget is essential if the VA is going to be able to continue to provide comprehensive and quality health care in the years ahead. The first two years of the Reagan Administration have witnessed pitched battles over the VA budget, especially the amount of money which should be allocated for veterans' health care. In 1981, the Administration proposed budget reductions for the VA of close to $800 million. Again, in 1982, reductions in the neighborhood of $400 million were proposed for VA health care. Those reductions were clearly unacceptable to those of us who feel a deep commitment to a quality VA health care delivery system. After many hours of heated and protracted debate in both House and Senate Chambers, we were able to restore crucial funding and curtail the damage.

For the first time in three years, I believe we have an adequate budget for the Department of Medicine and Surgery. We enacted the largest construction budget in the history of the agency which should help those of us who represent growth states. Nevertheless, I would hasten to point out that the VA budget has been shrinking in relation to other components of the Federal budget for a number

of years. Ten years ago, the VA budget constituted a 5% share of the budget. Today, its share of that budget has been reduced to a little more than 3%. Clearly, this trend must be reversed if the Veterans Administration is going to be prepared for the large group of World War II veterans who will be eligible for VA health care in the near future. Maintaining a quality VA health care system is going to cost a great deal of money at a time when budget deficits are looming at the $200 billion level for as far as the eye can see. As a result, budget battles will not subside. They will intensify and Congress will be forced to establish realistic national priorities from among competing and legitimate concerns. It is this Senator's view that the veterans' budget, especially the health care component, must remain near the top of the national agenda.

The current and future needs of the Arizona VA health care system are substantial. We need an expansion facility at Phoenix. We need a replacement facility at Tucson. We need a clinical addition at Prescott and a new domiciliary care unit. We desperately need nursing home and psychiatric beds. We need a Spinal Care Injury unit in Arizona to care for the large number of paraplegic and quadraplegic veterans in Arizona. We need automatic data processing systems at all three facilities to insure the most efficient and cost effective delivery of care possible.

In conclusion, I would like to thank once again the Chairman of the House Veterans Affairs Subcommittee on Hospitals and Health Care, Congressman Edgar, for holding these oversight hearings and hope that he will look into and help us resolve the problems brought forth in the testimony.

Thank you.

TESTIMONY

OF

CONGRESSMAN JAMES F. McNULTY, JR.

BEFORE THE

HOUSE VETERANS AFFAIRS COMMITTEE ON HOSPITALS

AND HEALTH CARE

November 22, 1983

San Francisco, California

CHAIRMAN EDGAR AND MEMBERS OF THE COMMITTEE:

I very much appreciate the opportunity to address the Committee on behalf of the 120,000 veterans of Congressional District Five in southeastern Arizona. These hearings, which you have held in every VA Medical district in the country, will provide the Committee the in-depth information necessary to develop legislation which improves our ability to meet the present health needs of veterans and to anticipate those of the future.

In an effort to better understand the health care needs of veterans in my district, I recently met with the Tucson Veterans Administration Medical Center staff, toured the hospital facilities, spoke with patients, reviewed institutional statistics and budgets, and studied the demographic trends that are making it imperative that I submit this testimony to you today, identifying problems which, if not addressed, will seriously threaten the Tucson VA Medical Center's ability to continue to deliver quality health care services.

In my testimony, I will call your attention to three service-delivery problems we face:

(1) The effects of rapid growth in the size of the veteran population in Arizona, which shows no signs of abating throughout this century.

(2) Acute space problems at the Tucson VA Medical Center which could be rectified by expediting construction of a new bed wing now included in the VA's five year plan for appropriation action, not before FY 1988, and

(3) The need to diversify the VA's capabilities for meeting the long-term health care needs of an elderly veteran population.

My District is one of the fastest growing in the nation. Southern Arizona has been growing at an extremely high rate since World War II: about 300 percent in the 1940's, 90 percent in the '50's, 32 percent in the '60's and 43 percent in the '70's. Projected growth estimates for the rest of the century vary widely from 30 percent to 500 percent, but a simple projection of recent trends would mean a population increase of almost 300 percent by the year 2,000. This is phenomenal growth!

Concomitant with this growth in the general population has been an increase in the veteran population, of all ages. Arizona is now among the top four states in the percentage of veterans in its population: twelve and one-half percent of the U.S. population are veterans, while the figure for Arizona is over fourteen percent. The proportionate presence of veterans in Arizona will continue to increase for at least the next quarter century.

We must prepare for this growth in the relative size of the Arizona veteran population because throughout the rest of this century, a constantly increasing percentage of the retired population moving to Arizona will be composed of veterans. In 1980, 33 percent of all males over age 65 were veterans; by the year 2000, 66 percent of this same group will be veteran.

This phenomenon of an increasingly aged veteran population will be discussed in the third section of this testimony. For the moment, my primary concern is to highlight the fact of a rapidly growing veteran population in Arizona and the unavoidably related issue of expanding our service delivery capabilities quickly enough to meet the growing demands which will be placed on the system. The medical center directors in Arizona can all relate the increasing troubles we now face in providing care. I as a Congressman, hear often about unconscienable waiting times before veterans are seen by a doctor and clinics which are closed because the demand for services far exceeds the resources to provide services. We all fear that these problems will not only continue, but actually increase in intensity over the upcoming years.

The Tucson VA hospital currently serves some 120,000 out-patients per year, an average of 460 per day. Even so, 12-40 percent of the 40 clinics are closed to non-service connected veterans at any given time. Some of the clinics currently closed are the high demand, high need ones of Allergy, Mental Hygiene, General Medical, Audiology, and Neurology.

In addition, waiting time for out-patient prescriptions is high. A service-connected veteran may wait up to two hours and a non-service connected veteran up to four hours!

While non-service connected veterans have second priority for care under the VA system, they are an increasing proportion of those seeking care, often because they have no other place to turn. Although none are refused hospitalization when in need, the non-service connected veterans are often denied the much less expensive out-patient care which could help to keep them at home, ambulatory and self-sufficient. A way must be found to provide a more humane and more cost-effective approach to medical care for these people in need.

In addition to the problems associated with the growth in the sheer numbers, there are other factors which may tend to increase the proportion of veterans seeking care at the VAMC. For example, increasing medical costs may drive some veterans out of the non-VA medical care systems. Thus, it is not too fanciful to argue that Medicare could become so restructured as to force veterans to seek VA care because Medicare was too expensive. Or, an increasingly elderly population of veterans with a disproportionately high number of people living alone, might lack alternative family insurance.

We can also expect some increased demands for services from specialized groups in addition to the elderly, a phenomenon occuring both here in Arizona and nationally. An increasing number of women veterans will soon be making demands on the system. In many of our wards there are no beds for women and in others, no bath facilities. In addition, special needs women veterans have, such as gynecological services, must be directly assessed and met.

The Vietnam Era veterans also have critical specialized needs. They can now receive treatment for any medical condition resulting from exposure to the dioxin in Agent Orange and on-going research in the medical consequences of this exposure could lead to an increase in the list of conditions eligible for treatment in the VA system.

More immediately, there are still many Vietnam Era veterans whose ability to adjust to and succeed in the larger society has been impaired by their wartime experiences and whose continuing needs for behavioral assistance have been denied or curtailed. Because of the demands placed upon the Tucson VAMC mental hygiene

clinic, they were forced to close the clinic to the long-term psychiatric cases who were not service-connected. These veterans were referred out into the larger mental health community, creating a major crisis for many providers. Mental hygiene clinics, psychiatric wards and substance-abuse programs must remain available so that these veterans can become integrated into the community again.

Thus, a combination of population factors--general population increase, plus a relatively faster growth in the older veteran population, most particularly--present the Tucson VAMC with a huge new demand on its existing health care facilities. If other costs and insurance arrangements remain substantially unchanged, then the demands for VA-provided health care will increase at an even faster rate. In our health care facilities, we are already experiencing the dislocations which result from receiving inadequate resources and our problems will grow. One telling example of the problems we are encountering already in health care delivery results from the physical limitations of our present facility.

The Tucson VAMC is a complex of some 32 buildings on 117 acres donated by the Chamber of Commerce, four miles from the city center. The main buildings of the complex are historic sites, built in the Spanish style around a courtyard, in 1928 to care for tubercular veterans. Thanks to VA research, the need for such care ended about 1958, and the facility was converted to general medical and surgical uses. A large clinical wing was added that year; twenty years later a new ambulatory care building was put into service. The hospital has had joint programs with the University of Arizona in Tucson since the establishment of the latter's Medical School in 1967. Teaching, research, and clinical services are shared.

The VA hospital has 325 medical-surgical beds, 41 nursing home beds, and serves some 460 out-patients per day. With an operating budget of $41 million, it has a staff of about 1,100, including 64 doctors, and about 290 in-house patients.

This hospital has been providing a full range of high quality medical services to its seven-county catchment area, except for open heart surgery which is currently done at the University Hospital. In addition, it is the only facility in the state providing renal transplants. It serves as a teaching hospital for the University and does considerable research which helps to maintain a high quality staff.

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The computerization of medical information to facilitate diagnosis and care has begun and will continue. The hospital will acquire a CT scanner in the next few months to increase its care capacity. A new clinical wing is currently under construction and will add new cardiac and surgical services, improve facilities in radiology, hemodialysis, dentistry and laboratories, and relieve crowding in these and in general supply. Finally, a new 120 bed nursing home wing has been approved for construction in 1986 to replace the existing 41 beds and to meet the needs of the rapidly expanding elderly population.

Although this hospital has provided admirable and enlightened service to the community for over 50 years, some problems remain and others will accelerate in the coming years. Unless existing problems are addressed and the challenge of the changing patient population is faced and planned for, the hospital will be unable to meet the predictable needs of the later '80s and '90s.

Even though the original buildings are substantial and some newer and more modern wings have been added, it is increasingly difficult to adapt the older buildings to newer equipment and more effective and efficient management styles. The long halls require considerable non-productive staff walking time, reducing patient access to care and increasing its cost. The old design of shared bedroom and bathroom space allows little privacy. Although many large wards have been divided, some 10-20 patients must often share bath facilities. This means long walks, much staff time, little privacy, and few facilities for the increasing number of female veterans.

The Supply Storage, too, is inadequate, again requiring long walks, waste of expensive staff time, and occasional neglect of the physically isolated patient. In general, the old style buildings, though elegant in appearance, are quite inefficient in the provision of adequate patient care.

During my most recent visit, I observed the crowding in the acute and intensive care areas where current practice often requires 10-12 doctors to visit one patient simultaneously. Where spaces are barely sufficient to house the bed alone, crowding routinely occurs in these areas, making modern care difficult to render. These areas need expanded spaces which allow the staff to function more efficiently.

The VA's five-year construction plan does now include provision for seeking an appropriation for a new bed wing at the Tucson VAMC. The present plans call for requesting the appropriation in FY 1988. We are grateful that the need for this new

wing has been acknowledged, but are fretful over the prospect of waiting for eight to ten years before it can be opened. We feel that the veterans of southeast Arizona would be far better served if the construction timetable could be advanced.

Finally, let us consider the larger, more aged veteran population about to demand services from our facility. Forty percent of all living veterans served during World War II. Most of them will reach 65 in the next decade. The number of veterans over 65 will double in five years and triple in ten. Today, 1/3 of all males over the age of 65 are veterans; by the year 2000, 2/3 of all males over 65 will be.

Based on this demographic data, while 40 percent of those currently served at the Tucson VAMC are elderly, we can expect this proportion to reach 57 percent in 1985 and 67 percent by 1990. Of this increasingly aged population, there are three important points to be made relating to their health care. First, there will be more of them--twice as many--demanding more of a whole range of services; second, they will be older, demanding a <u>different</u> distribution of services; and third, many will demand more <u>intensive</u> care, particularly more nurses per person.

Our VAMC has had the foresight to hire a geriatric physician, and to begin to plan services to meet this developing need. But this is only a first step. One and a half percent of the physician staff is insufficient to deal with the special needs of 40 percent of the patient population which will soon grow to 70 percent. Older patients have <u>different</u> needs in a whole complex of areas. Considerably more staff physicians, therapists, nurses and support personnel,sensitive to these differences, are needed now and increasingly over the next decade.

In addition, a more centralized physical plant to serve less mobile patients is necessary, as well as new systems that effectively coordinate home and hospital care, and extend independent mental and physical functioning to allow them an improved quality of life.

The new Nursing Home facility will meet the needs of the least capable of this group, but this is the tip of the iceberg. Much more is needed, particularly in geriatric trained staff, to increase the proportion of elderly veterans capable of extended independence. Support systems to assist those needing partial medical care, plus retraining in self-care for those learning to adjust to the reduced capacities of old age, is essential for mental and physical health of the patient, his/her family, and for the community as a whole. We can in no way afford the total dependence of

this huge segment of the population, nor do the veterans choose it if they can avoid it. Ways must be found.

As we plan for the treatment of an aged veteran population, we must look to models of geriatric care which does not concentrate only on acute care, but looks also to the provision of long-term ambulatory care. In this respect, I believe we need to explore mechanisms for integrating the VA and its client population into the larger geriatric health care system. I do not believe that a VA medical center would ever be able to provide, on its own, the entire range of geriatric services, especially when most clients have multi-dimensional care needs.

Therefore, VA medical centers need to become more active, continuous participants in the planning of long-term geriatric care. We should fully examine approaches which would permit a local VAMC to contract with other service providers for aspects of geriatric care. And, of particular importance to my District, the VA should, in cooperation with other providers, investigate the issue of providing long-term geriatric care to an elderly, rural veteran population. Research, training and, most of all, staffing patterns must reflect this need.

In summary, the following is a list of the major components of veterans' medical care needing additional funding support in Tucson in the near future:

1) A New Bed Facility to replace the existing 325 outdated medical/surgical beds, and add 75 new ones, including facilities for an anticipated 50 percent increase in outpatient load to accommodate regional growth.

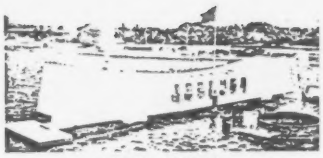
2) Funding to open needed outpatient clinics to non-service connected veretans, and to reduce all waiting times to less than one hour.

3) Funding for trained geriatric support personnel and the development of new effective systems to facilitate extended patient independence through physical and occupational therapy, day and home care.

4) Funding to increase staff skill and patient access for victims of new chemicals and/or radiation.

In closing, I wish again to thank Chairman Edgar and the Committee for the opportunity to submit this testimony on behalf of the 120,000 veterans of my District. I am sure that the Committee will do all it can to assure that our veteran population is adequately and respectably care for, and that planning for their future needs is not neglected. We owe our veterans no less than this, and it will benefit the community as a whole if the VA medical centers are allowed to fulfill their mission.

(1) Veterans' Administration Health Care of the Aging Veteran: A Report to the Geriatric and Gerontological Advisory Committee, USG PO, Washington, D.C. April 1983.



ARIZONA MEMORIAL

ARIZONA VETERANS SERVICE COMMISSION
700 W. Campbell, Suite 17 • Phoenix, Arizona 85013
(602) 255-4713

Bruce Babbitt
GOVERNOR

Richard L. Countryman
DIRECTOR, Veterans Affairs

31

Insert

November 14, 1983

Mr. Bob Edgar
Chairman, Subcommittee on
Hospitals and Health Care
U.S. House of Representatives
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, D.C. 20515

Dear Mr. Edgar:

I appreciate the opportunity to present testimony before the Veterans Affairs Subcommittee on Hospitals and Health Care Oversight Hearings on behalf of the Arizona Veterans Service Commission and the veterans of Arizona.

As a general statement of our problems in Arizona, the following must be said: Arizona is the second fastest growing State in the Union. Its veteran population obviously grows in direct proportion to the general population. Resources in health care to veterans in Arizona have not been addressed in direct relationship to the increase. In view of these facts, funds and resources from areas decreasing in veteran populations must be made available to areas where veterans are actually located. This may result in closing some hospitals in order to enlarge or establish hospitals where needed. Arizona has a tremendous influx of transient veterans in the fall and winter months. While this is probably a boon for the Arizona economy, it is devastating for the VA Health Care system. If funds were made available today, it would still take several years to establish the additional facilities needed and to find and hire the personnel to staff them.

We of the Arizona Veterans Service Commission have the utmost respect and confidence in the Directors of our three Veterans Administration Medical Centers and their staffs and it is not our purpose to find fault with them or their efforts to meet our needs. We realize they have an impossible task. In Arizona we are on the brink of disaster and, if steps are not taken now to address the problems neglected for far too long, the entire system in Arizona will collapse. For example, one extremely frustrating problem is the pharmacy at VAMC, Phoenix. Until recently it was taking in excess of seven weeks to have a prescription mailed to veterans needing refills. This problem is now somewhat improved, but still not what it should be. Seeing a doctor and having medicine prescribed is useless if one cannot get the medicine in a timely manner. It may appear on paper that if they have no vacant positions all three medical centers have full staffs. The problem, however, is that the allotted staffs are far too small for the population they are called upon to serve. This is true in all areas, including out-patient clinics, specialty clinics, nursing home beds, hospital beds, etc. At the state level we are working towards the establishment of a

State Veterans Home, including a nursing home facility. Unfortunately, it will be several years before that is a reality.

Arizona's excellent climate attracts people of all ages; the young (not yet established), feel they would like to settle in a growing state, and the old choose to retire in our mild climate. We have an unusually high percentage of Vietnam Veterans and the older World War II veterans. Arizona is also a state large in land area with many small communities far removed from the three Veterans Administration Medical Centers. Included in these areas far from the VAMC are our Indian reservations. The Navajo Reservation (the largest in the U.S.), has approximately 14,000 veterans all living hundreds of miles from any Veterans Administration facility. Arizona does not have even one VA Out-patient Clinic outside of the three VA Medical Centers and it certainly appears that some thought should be given to the establishment of out-patient clinics. While we have our doubts about the present experimental program of mobile out-patient vans, we would welcome the chance to try them.

We also know that Arizona has one of the highest populations of paraplegic and quadraplegic veterans in the U.S. We have another large group of wheel chair veterans living in Mexico who come regularly to the VAMC, Tucson and sometimes to Phoenix for care. We do not have a Spinal Cord Injury Center in Arizona and we urge that one be established here. VAMC Tucson presently cooperates with the University of Arizona and it is not unreasonable to expect a Spinal Cord Injury Center to be established at VAMC Tucson.

The quality of life and the pursuit of happiness which all American citizens are led to believe is their right, should be no less for veterans. Part of that quality of life and happiness is the knowledge that when a veteran's life is over, he or she can be buried in a National Cemetery near home, or at least in the same state they have chosen to call home. For over forty years Arizona veterans have worked to establish a National cemetery. In cooperation with the State of Arizona, they have at last established a State cemetery in Phoenix, The Arizona Veterans Memorial Cemetery. They were led to believe that would lead to the conversion of that cemetery into a National cemetery. Now they are told that the federal government has a regionalization concept and, if they wish to be buried in a National cemetery, they must be buried in Riverside, California. This additional slight on behalf of a grateful nation does little to contribute to the mental tranquility of our Arizona veterans. Mental tranquility, without question, contributes greatly to overall good health. We find ourselves unable to make a presentation before our National Leaders without calling attention to this problem. House Bill H.R. 1906 would correct this inequity.

A request was addressed to all three Directors of Arizona's Veterans Administration Medical Centers asking them to tell us of their problems and needs. To date, two of the Directors have responded, copies of which are enclosed for the Committee's information.

Again, on behalf of the Arizona Veterans Service Commission and the veterans of Arizona, I appreciate and thank you for the opportunity to present this testimony before this distinguished Committee.

Richard L. Countryman

RLC:rs
encs.

Medical Center Prescott AZ 86313

Veterans Administration

November 4, 1983

In Reply Refer To: 649/002

Mr. Richard L. Countryman
Director, Veterans Affairs
Arizona Veterans Service Commission
700 West Campbell, Suite 17
Phoenix, Arizona 85013

Dear Mr. Countryman:

We appreciate your concern for the veterans of Arizona and welcome your support. The following comments speak to our most urgent needs.

System-wide Problems:

1. The VA has not been able to provide its medical centers with budgets that keep pace with inflation. With the cost of health care increasing even more rapidly than costs in general and the inflation rate, this results in a significant "real dollar" loss. This has occurred during a period when the demand for services from the VA has increased dramatically.

2. Adequate resources are not available to manage the additional administrative requirements that have been imposed on clinical and administrative services (e.g., Quality Assurance, Diagnosis Related Groups, Continuing Medical Education, etc.).

3. Expanded eligibility provides access to the VA health care system for increasing numbers of veterans. Resources have not been forthcoming to manage this additional workload. In addition, the VA health care system is expected to provide more specialized medical care (e.g., a new Domiciliary Program mission, Agent Orange issues, Vietnam Veteran issues, and the problems of the aging veteran).

4. On the other hand, eligibility restrictions often preclude the treatment of the total medical needs of the veteran patient (e.g., service connected vs. non-service connected, limitations on outpatient care and care of chronic diseases, etc.).

Needs of the Prescott VA Medical Center

1. Adequate resources are needed to treat all patients, but special needs are evident in the following areas:

   a. Oncology
   b. Respiratory problems
   c. Rehabilitation

Mr. Richard L. Countryman

2. Administrative support must be increased to our clinical functions, especially in view of quality assurance issues and the application of Diagnosis Related Groups as a workload indicator.

3. Our space needs are critical but are being addressed by the VA Central Office. We have been approved to build a 120-bed Nursing Home Care Unit and are in the process of obtaining approval for a new clinical building, renovation of the existing hospital, and possibly construction of a new Domiciliary. We are also in line for receiving automated data processing equipment which will significantly improve our administrative operations.

Thank you again for your interest in the veterans of Arizona. We hope the above information will be useful.

Sincerely,

V. I. McINTYRE
Medical Center Director

30-369 O - 84 - 6

Medical Center

Seventh Street and Indian School Road
Phoenix, AZ 85012

Veterans Administration

November 2, 1983

In Reply Refer To 644/00

Mr. Richard L. Countryman
Arizona Veterans Service Commission
700 W. Campbell, Suite 17
Phoenix, AZ 85013

Dear Mr. Countryman:

We are thankful for the opportunity to share with you and the members of the Unified Arizona Veterans issues of importance to the veterans served by the Phoenix VA Medical Center.

The provision of organized medical care must always be future oriented. The forces of medical advances, economic changes, new legislative directions and population shifts will impact no less on this VA Medical Center than on any other provider of medical care. Accordingly, these changing conditions must be assessed as best we are able and placed in their proper importance.

We must recognize the medical needs of the veteran are changing as the veterans themselves are changing. The patients' average age is increasing rapidly. The diseases plaguing them are changing. The ability to meet these changing needs will require an assessment of the way we utilize our current staff and a recognition that, as the patient requires more care, staffing levels must be adjusted accordingly.

The issues that I will be focusing on have been chronic problems facing our Medical Center. I have discussed many of these same issues at a previous oversight hearing in January of 1982. A few of the areas of concern are currently being addressed and will hopefully disappear in the forseeable future. Other problem areas have escalated in the past few years and are reaching the point of serious gravity.

In terms of progress since the last hearings, the Phoenix VA Medical Center will finally secure a Computerized Axial Tomography Scan (CAT) later this fiscal year. Automated data processing equipment is being installed and staff are being trained to utilize this technology. This will result in the elimination of many routine and antiquated tasks which have long hampered efficiency and progress.

Although we are appreciative of these improvements, it is somewhat distressing that many of our medical centers must lag behind that which is standard in the community and then resort to catch-up technology.

The most serious concern confronting our Medical Center is the growing demand for patient services coupled with insufficient increases in resources to meet this demand. The majority of other problems at our Medical Center can find root in this single issue. While the entire Southwest is rapidly gaining in population, the area served by the Phoenix VA Medical Center has experienced an explosive growth; a rate of growth that has not stopped and, from all predictions, will expand an additional 57 percent during the decade ahead. The Phoenix VA Medical Center was never designed to treat the number of veterans now seeking care. A system-wide process, titled Medical District Initiated Planning Process (MEDIPP) has focused in on this and other related issues resulting in an approved addition of 130 additional beds for Phoenix by 1990. Our concern is the timely manner of the implementation of this process. It is realized that delaying construction saves dollars for the present, but in the long term it leads to increased costs. Furthermore, this ever increasing demand for services is causing a serious stress on our already understaffed work force. The veterans served by the Phoenix VA Medical Center have been receiving quality medical care which can be attributed to the dedication and professionalism of our staff. However, we cannot expect our personnel to maintain a high level of morale and remain in a system which is constantly threatened with staff and budgetary reductions followed by an ever increasing workload. This is unrealistic.

In addition to manpower deficiencies, dollars are another resource which has been in scarce supply at the medical center. Management processes are difficult to keep on a consistent level with wide fluctuations in budgetary support. This center has historically had a significant portion of its budget in the form of nonrecurring funds. This precludes good planning and good budget execution. The Regional Director and Central Office officials have recognized this condition and are providing for a change in the ratio of recurring and nonrecurring funds. It is expected that the Phoenix VA Medical Center will find further relief from this nagging situation in Fiscal Year 1985 as the Veterans Administration resorts to funding its hospitals on the basis of Diagnostic Related Groups (DRG's).

Although we welcome the opportunity to expand our services to an ever increasing veteran population base. the growing pains are becoming increasingly evident. The proposed clinical

addition is badly needed and, in light of current demand, is already overdue. Parking inadequacies, space deficiencies, an increasing rate of patient violences, and various other concerns all have cascaded from a single issue. This issue, the central theme of this letter, is such the Phoenix VA Medical Center is not allocated an appropriate matching of resources to meet the increasing demand for services. Unless this issue receives some prompt remedial attention, the upcoming years will prove increasingly trying to both patients and staff.

Your interest and concern in these issues is gratifying and I wish to thank you for the opportunity to share with you our needs regarding the future ability of our Medical Center to meet the medical needs of our veterans.

Sincerely,

RAY L. BOURNE
Medical Center Director

ARIZONA MEMORIAL

ARIZONA VETERANS SERVICE COMMISSION
700 W. Campbell, Suite 17 • Phoenix, Arizona 85013
(602) 255-4713

Bruce Babbitt
GOVERNOR

Richard L. Countryman
DIRECTOR, Veterans Affairs

January 12, 1984

Mr. Bob Edgar
Chairman, Subcommittee on
Hospitals and Health Care
U. S. House of Representatives
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, D.C. 20515

Dear Representative Edgar:

As requested by you during our appearance before the House of Representatives, Veterans' Affairs Subcommittee on Hospitals and Health Care oversight hearing on Tuesday, November 22, 1983, we submit the following.

Upon our return to Arizona, we have again contacted the three VA Medical Center Directors and the Department Service Officers of the major veterans organizations.

A copy of a letter from the VA Medical Center Directors is enclosed.

Our meeting with the Department Service Officers indicated their agreement with the VA Medical Center Directors for the immediate future. That being that before anything else is done, all three VA Medical Centers should have their deficits corrected.

After the three VA Medical Centers have deficiencies eliminated, the following long range plans are suggested.

1. Utilize military medical facilities in Arizona for veterans' health care. Military medical facilities in Arizona are marked on the enclosed map by red circles.

   a. Ft. Huachuca Army medical facility
   b. Army Proving Ground, Yuma, Arizona

c. Marine Corps Air Station, Yuma, Arizona
d. Luke Air Force Base, Litchfield Park, Arizona (west of Phoenix)
e. Williams Air Force Base, Chandler, Arizona (east of Phoenix)
f. Davis Monthan Air Force Base, Tucson, Arizona

2. Utilize U. S. Public Health Service Indian Hospitals with priority for service-connected veterans. Indicated on enclosed map with blue circles. U. S. Public Health Service Indian Hospitals are located as follows:

a. Tuba City, Arizona
b. Kayenta, Arizona
c. Chinle, Arizona
d. Ft. Defiance, Arizona
e. Keams Canyon, Arizona
f. Whiteriver, Arizona
g. Sells, Arizona
h. Parker, Arizona
i. San Carlos, Arizona

3. Expand fee basis service for use in communities not covered by the above. Suggested locations are circled in black on the enclosed map.

a. Flagstaff, Arizona
b. Kingman, Arizona
c. Globe, Arizona
d. Show Low, Arizona

Representative Edgar, Mr. Blakely and I, on behalf of all the veterans in Arizona, thank you and the members of your Subcommittee for allowing us to testify and bring to your attention the hospital and health care problems of the veterans in Arizona.

Respectfully,

Richard L. Countryman
Director of Veterans' Affairs

Louis G. Blakely, Commissioner
Veterans Service Commission and
Representative of the Unified Arizona
Veterans

RLC/LGB/iw

Enclosures (3)

Medical Center

Seventh Street and Indian
School Road
Phoenix, AZ 85012

Veterans
Administration

December 28, 1983

In Reply Refer To 644/00

Mr. Richard L. Countryman
Arizona Veterans Service Commission
700 W. Campbell, Suite 17
Phoenix, AZ 85013

Dear Mr. Countryman:

Thank you for sharing the testimony you gave to the recent Congressional Oversight Committee Hearing. I believe you represented the interests of Arizona veterans in a most able manner.

Various planning activities have identified, specifically, needs of the Medical Centers in Arizona. The letters furnished to you by each of the Center Directors have one common theme. We simply don't have adequate resources to meet the veterans' needs; resources for equipment, resources for staff, resources for establishment of treatment programs, resources for land and buildings.

This has been an oft voiced concern of our Arizona facilities, however, it continues to be the major issue facing our Medical Centers. I don't believe we should consider other kinds of outreach activities (i.e., traveling vans, outpatient clinics) until we have resolved the deficits currently being experienced. We have increased our services to veterans, we have refined our approaches to care, we have made our Medical Centers more efficient. These efforts have been our response to increased needs. We have exhausted our ingenuity and, increasingly so, exhausted our staff.

We will continue to work with you and to serve the veteran. Any help you may offer will be gratefully received.

Sincerely,

GAYLORD V. MORTON
Medical Center Director
VAMC, Tucson

VIRGIL I. McINTYRE
Medical Center Director
VAMC, Prescott

RAY L. BOURNE
Medical Center Director
VAMC, Phoenix

ARIZONA

VETERAN POPULATION BY COUNTY --- MARCH 31, 1983

COUNTY	TOTAL VETERANS	WAR VETERANS	VIETNAM ERA	VIETNAM ERA, NO SERVICE IN KOREAN CONFLICT	KOREAN CONFLICT	KOREAN CONFLICT, NO SERVICE IN WORLD WAR II	WORLD WAR II	WORLD WAR I	POST-VIETNAM ERA	SERVICE BETWEEN KOREAN CONFLICT AND VIETNAM ERA ONLY	OTHER PEACETIME VETERANS
TOTAL	383,000	316,000	120,000	105,000	73,000	53,000	154,000	5,000	24,000	38,000	5,000
APACHE	3,230	2,490	1,050	1,030	360	330	1,110	20	360	340	40
COCHISE	12,610	10,600	4,510	3,300	3,300	1,990	5,250	70	890	930	190
COCONINO	8,290	6,520	3,330	3,250	1,160	940	2,280	60	640	1,000	130
GILA	5,290	4,430	1,160	1,070	940	800	2,510	60	370	440	50
GRAHAM	2,650	2,210	820	780	440	360	1,030	30	170	260	10
GREENLEE	1,330	1,140	430	400	270	240	490	*	70	130	*
MARICOPA	218,160	180,110	68,040	60,360	41,490	30,690	86,450	2,620	12,820	22,370	2,870
MOHAVE	10,120	8,580	2,300	1,980	1,990	1,480	5,040	90	460	920	160
NAVAJO	5,600	4,550	1,820	1,690	880	740	2,070	50	320	700	30
PIMA	78,800	65,170	26,660	22,210	16,020	10,440	31,430	1,090	5,430	7,270	940
PINAL	11,740	9,550	3,430	3,150	2,180	1,710	4,560	130	630	1,260	300
SANTA CRUZ	1,880	1,510	440	420	310	250	820	20	80	130	80
YAVAPAI	11,460	9,950	2,330	2,070	1,800	1,160	6,460	250	370	930	220
YUMA	11,720	9,600	3,750	3,100	2,240	1,590	4,810	100	1,020	940	170

NOTE: DETAIL MAY NOT ADD TO TOTAL SHOWN DUE TO ROUNDING. "OTHER PEACETIME VETERANS" IS COMPRISED OF THOSE WHO SERVED ONLY BETWEEN WORLD WAR I AND WORLD WAR II, AND THOSE WHO SERVED ONLY BETWEEN WORLD WAR II AND THE KOREAN CONFLICT.
* LESS THAN 5. ** LESS THAN 500.

*Population figures furnished by VA statistical service and possibly do not include the retired military personnel who use the military installations medical facilities. Total veteran population probably exceeds 400,000.

STATEMENT OF

LOUIS S. BLAKELY

MEMBER - UNIFIED ARIZONA VETERANS

COMMISSIONER - ARIZONA VETERANS SERVICE COMMISSION

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

COMMITTEE ON VETERANS AFFAIRS

HOUSE OF REPRESENTATIVES

OVERSIGHT HEARING NOVEMBER 22, 1983 SAN FRANCISCO, CALIFORNIA

Mr. Chairman and Members of the Subcommittee

I am pleased to have the opportunity to present some views of the Unified Arizona Veterans in regards to inpatient and outpatient Veterans' Administration health care in the State of Arizona.

The Unified Arizona Veterans is a group of veterans organizations that have joined together for the purpose of representing all veterans throughout the State of Arizona and to promote all worthwhile endeavors of veterans organizations.

In Arizona we are fortunate to have three Veterans' Administration Medical Centers. The Phoenix VAMC has 470 beds with an additional 120 beds in nursing care facilities; the Tucson VAMC has 325 beds with 41 beds in nursing care and, the Prescott VAMC has 212 beds and a domiciliary of 220 beds.

The issues of importance to the veterans served by the Phoenix VAMC are outlined in the following statement by Mr. Ray L. Bourne, the Medical Center Director.

"We are thankful for the opportunity to share with the members of the Unified Arizona Veterans issues of importance to the veterans served by the Phoenix VA Medical Center.

The provision of organized medical care must always be future oriented. The forces of medical advances, economic changes, new legislative directions and population shifts will impact no less on this VA Medical Center than on any other provider of medical care. Accordingly, these changing conditions must be assessed as best we are able and placed in their proper importance.

We must recognize the medical needs of the veteran are changing as the veterans themselves are changing. The patients' average age is increasing rapidly. The diseases plaguing them are changing. The ability to meet these changing needs will require an assessment of the way we utilize our current staff and a recognition that, as the patient requires more care, staffing levels must be adjusted accordingly.

The issues that I will be focusing on have been chronic problems facing our Medical Center. I have discussed many of these issues at a previous oversight hearing in January of 1982. A few of the areas of concern are currently being addressed and will hopefully disappear in the forseeable future. Other problem areas have escalated in the past few years and are reaching the point of serious gravity.

In terms of programs since the last hearings, the Phoenix VA Medical Center will finally secure a Computerized Axial Tomography Scan (C/T) later this fiscal year. Automated data processing equipment is being installed and staff are being trained to utilize this technology. This will result in the elimination of many routine and antiquated tasks which have long hampered efficiency and progress.

Although we are appreciative of these improvements, it is somewhat distressing that many of our medical centers must lag behind that which is standard in the community and then resort to catch-up technology.

The most serious concern confronting our Medical Center is the growing demand for patient services coupled with insufficient increases in resources to meet this demand. The majority of other problems at our Medical Center can find root in this single issue. While the entire Southwest is rapidly gaining in population, the area served by the Phoenix VA Medical Center has experienced an explosive growth; a rate that has not stopped and, from all predictions, will expand an additional 57 percent during the decade ahead. The Phoenix VA Medical Center was never designed to treat the number of veterans now seeking care. A system-wide process, titled Medical District Initiated Planning Process(MEDIPP) has focused in on this and other related issues resulting in an approved addition of 130 additional beds for Phoenix by 1990. Our concern is the timely manner of the implementation of this process. It is realized that delaying construction saves dollars for the present, but in the long term it leads to increased costs. Furthermore, this ever increasing demand for services is causing a serious stress on our already understaffed work force. The veterans served by the Phoenix VA Medical Center have been receiving quality medical care which can be attributed to the dedication and professionalism of our staff. However, we cannot expect our personnel to maintain a high level of morale and remain in a system which is constantly threatened with staff and budgetary reductions followed by an ever increasing workload. This is unrealistic.

In addition to manpower deficiencies, dollars are another resource which has been in scare supply at the Medical center. Management processes are difficult to keep on a consistent level with wide fluctuations in budgetary support. This center has historically had a significant portion of its budget in the form of nonrecurring funds. This precludes good planning and good budget execution.

The Regional Director and Central Office officials have recognized this condition and are providing for a change in the ratio of recurring and nonrecurring funds. It is expected that the Phoenix VA Medical Center will find further relief from this nagging situation in Fiscal Year 1985 as the Veterans Administration resorts to funding its hospitals on the basis of Diagnostic Related Groups (DRG's).

Although we welcome the opportunity to expand our services to an ever increasing veteran population base, the growing pains are becoming increasingly evident. The proposed clinical addition is badly needed and, in light of current demand, is already overdue. Parking inadequacies, space deficiencies, an increasing rate of patient violences, and various other concerns all have cascaded from a single issue. This issue, the central theme of this letter, is such the Phoenix VA Medical Center is not allocated an appropriate matching of resources to meet the increasing demand for services. Unless this issue receives some prompt remedial attention, the upcoming years will prove increasingly trying to both patients and staff.

Your interest and concern in these issues is gratifying and I wish to thank you for the opportunity to share with you our needs regarding the future ability of our Medical Center to meet the medical needs of our veterans." End of statement.

The Tucson hospital is a teaching and research center. The problems related to this facility are outlined in the following statement of Center Director Mr. Gaylord Morton presented originally to the United States Senate Oversight Hearing on Veterans' Health Care Issues in Arizona on January 26, 1982.

"The Tucson VA Medical Center is an accredited 325 bed teaching and research center with a 41 bed nursing home care unit, with a budget of $[illegible] million and a staff of 905. We estimate that there are over [illegible],000 veterans within our jurisdiction. Last Fiscal Year we treated

over 9,000 in-patients and we had over 121,700 out-patient visits.

Due to the Arizona climate, the veterans population has continued to grow during this decade. In addition to the increased population, we also are faced with the advancing age of the veterans. These two factors will have a major impact on the VA health care delivery system. The typical VA patient will not only be older, but will have more complex problems requiring additional care.

A GAO study predicts that by the year 1990 we will have demands for services to support 530 beds or over 60 percent more than our present capacity. Demand for outpatient services would almost double, from 119,000 visits in 1980 to 228,000 by the end of the decade.

Our problems can be reduced to one word: "resources"--resources in terms of space, staffing, equipment, and funding to meet these demands. Staffing difficulties are not unique to our center. The shortage in nursing is a nationwide phenomena. During October 1981 we had to restrict admissions to our intensive care unit. We referred patients to community intensive care units at a cost of almost $100,000. Our nursing staff has an admirable job overextending themselves to keep our beds open.

Although our staffing appears to be in line when compared to other VA hospitals, the acuity of the illness of the veterans necessitates more care. Our needs extend to paraprofessionals and selected specialties in medicine as well.

An example of the impact of budgetary limitations was the severe cutback in the VA medical research budget, one of our attractive qualities to physicians. If the VA is unable to offer this incentive, we will begin to lose our clinicians, resulting in the constriction of services. This is compounded by limited travel funds to relocate qualified applicants, particularly physicians. Without travel monies, we are unable to pay relocation expenses.

We also have been unable to provide our specialized services due to funding limitations. We do not offer computerized tomography or ultrasound. We rely on the Arizona Health Science Center for these and other services at a cost of over $1 million in Fiscal Year 1981. This cost is not even representative of the actual demand because budgetary limitations force us to restrict the availability of these procedures.

Furthermore, patients whose need for the procedures is most urgent--those too ill to be transported--are the ones denied these procedures. We do not expect nor desire to obtain all the advanced technology equipment available. We shall continue to share resources with the community and only acquire services when the demand is sufficient.

Another critical problem that we at Tucson face is the lack of computer support. Laboratory test results are hand-delivered to our wards, delaying clinical access to patient information. Much-needed management information still has to be assessed and compiled through a time-consuming manual process.

Our patient wards are antiquated and inadequate. The building was constructed in the early 1930's. We will start construction of a new building this year which will alleviate some of our space deficiencies. This new clinical building, however, will not affect most of our wards and they will remain inefficient. We need a new bed wing. We have addressed these as part of our facility planning program, but ultimate resolution will still be contingent on the availability of funds.

We share a common problem with the other medical centers in our district--access to long-term psychiatric facilities. In the past we have been able to transfer our patients to other VA centers. However, these facilities are now reluctant to accept our patients because they, too, are faced with increased demand for services.

We at Tucson VA will continue to address these problems and do utmost to provide the service in the most cost-effective manner. Congress, however, must realize that we will need an enormous amount of support to continue to provide the care that our veterans need and deserve." End of statement.

Issues of concern of the veterans of Arizona and needs of the Prescott VAMC are listed in the following statement of Mr. Virgil I. McIntyre, Director of the Center.

"We appreciate your concern for the veterans of Arizona and welcome your support. The following comments speak to our most urgent needs.

System-wide Problems:

1. The VA has not been able to provide its medical centers with budgets that keep pace with inflation. With the cost of health care increasing even more rapidly than costs in general and the inflation rate, this results in a significant "real dollar" loss. This has occurred during a period when the demand for services from the VA has increased dramatically.

2. Adequate resources are not available to manage the additional administrative requirements that have been imposed on clinical and administrative services (e.g., Quality Assurance, Dianosis Related Groups, Continuing Medical Education, etc.).

3. Expanded eligibility provides access to the VA health care system for increasing numbers of veterans. Resources have not been forthcoming to manage this additional workload. In addition, the VA health care system is expected to provide more specialized medical care (e.g., a new Domiciliary Program mission, Agent Orange issues, Vietnam Veteran issues, and the problems of the aging veteran).

4. On the other hand, eligibility restrictions often preclude the treatment of the total medical needs of the veteran patient (e.g., service connected vs. non-service connected, limitations on outpatient care and care of chronic diseases, etc.).

Needs of the Prescott VA Medical Center

1. Adequate resources are needed to treat all patients, but special needs are evident in the following areas:

a. Oncology

b. Respiratory problems

c. Rehabilitation

2. Administrative support must be increased to our clinical functions, especially in view of quality assurance issues and the application of Diagnosis Related Groups as a workload indicator.

3. Our space needs are critical but are being addressed by the VA Central Office. We have been approved to build a 120 bed Nursing Home Care Unit and are in the process of obtaining approval for a new clinical building, renovation of the existing hospital, and possibly construction of a new Domiciliary. We are also in line for receiving automated data processing equipment which will significantly improve our administrative operations.

Thank you again for your interest in the veterans of Arizona. We hope the above information will be useful." End of statement.

The veteran population has been increasing since World War II with 385,000 veterans of which 35,000 are service connected disabled now permanently established in Arizona. During the winter months the veteran population swells because of the influx of veterans seeking a haven from the severe cold of the northern and northeastern states. Because of this tremendous influx of winter visitors, the inpatient and outpatient facilities are greatly overtaxed at all three VAMC's.

It is most difficult to obtain VA nursing care beds even for veterans with service connected disabilities. Nursing care for non-service connected veterans is subject to the availability of funding for contracting out to community facilities. Of course the VA medical care problems are intensified as Arizona is the only state which does not have a Medicaid program. However, an alternative health care plan to Medicaid was launched in 1982.

Beginning October 1, 1982 the State of Arizona offered residents a new health care plan called ACCESS, which stands for the Arizona Health Care Cost Containment System. AHCCCS is a division of the Arizona Department of Health Services.

Persons who can enroll in ACCESS are those receiving Supplemental Security Income (SSI) or Aid to Families with Dependent Children (AFDC). Other residents of Arizona who meet certain financial requirements and whose annual income is:

single person	0 to $3200
married persons	0 to $4266
for each dependent add	$425 to $544

At the present time there are problems in the management of ACCESS. Considerable controversy along with what appears to be inept handling of funds (payment to providers) are being investigated. It is most likely that the handling of the new health care plan has led to a breakdown in the public's confidence in the State Government.

When a mentally handicapped youngster having multiple handicaps, working in a sheltered workshop whose fluctuating earnings average between 30¢ and 60¢ per hour cannot qualify for the ACCESS program then it is highly probable that not many veterans would qualify.

There's a question of whether the nation can care for its growing number of old soldiers, sailors and airmen in the years ahead. There will be 9 million veterans aged 65 years and older by the year 2000, triple todays number.

Arizona was the fastest growing state in the nation during the past decade after Nevada. The growth was 53.5 percent between 1970 and 1980.

Arizona is projected to have 5.6 million total population in year 2000, up from 2.8 million presently. In the new projections, the West is expected to grow 22 percent in this decade and 18 percent between 1990 and year 2000. The veterans population in Arizona will swell to 469.7 thousand by 1990 and to 507.3 thousand by the year 2000.

There are many problems within the VA Medical Centers in Arizona that I now address. These comments pertain mainly to the Phoenix VAMC.

In the scheduling of appointments----To get an appointment with a particular doctor or clinic the veteran must go through the general medical clinic first. He must appear in person to the general clinic, wait in line and register with the records clerk. He then signs in at the Triage Unit, where his complaint is recorded along with his temperature and blood pressure but only after his medical records are brought from the Records Room. He then is required to go to a waiting room and wait until the doctor calls him to an examining room. After this consultation the doctor may refer the patient to the doctor or clinic he originally requested.

This is a change from the past practice where a veteran could call the scheduling clerks and make an appointment with a doctor or clinic of choice per telephone.

The veterans recommendation is the return of telephone scheduling.

Concerning initial prescription fulfillment or re-fill of unexpired prescriptions. If the veteran appears at the pharmacy he may experience a wait from 2½ to 4 hours for his medication. If he delivers the Rx to the pharmacy and request the medication be mailed, then it is not uncommon to wait a week or more for the medication. Problems are also experienced in numerous cases where unexpired Rx refill requests are returned with the notation that "additional refills are not authorized". Oft times medication is available at one hospital and not the others. It is reported that the pharmacists have on occasion, denied medication prescribed by a doctor simply by stating that "the medication had not proven to be effective in treatments".

Considerable complaints are made about being on a drug(s) for years without an absorption check by blood test. Also related to this subject is the prescribing of a drug for a condition without checking

to see if the patient is taking other drugs that may not be compatible to the new drug.

Recommendation by the veterans is up dating the filing of prescription forms immediately so future Rx requests will not be returned as "not refillable", that the pharmacist never override a doctors Rx without first conferring with the physician, that medication absorption be checked regularly for tolerance and a drug profile be made on each drug issued. A much needed computer has been received and is now in place. The electrical hookup has not been completed. With this new computer, when operating, should provide a drug profile capability that will aid in the over prescribing of drugs and eliminate the issuance of a drug that will counter react with another prescribed drug.

Security-- Four suicides, an attempted rape of a women employee in an elevator, a hostage situation where the veteran gunman's girl friend received a non-fatal gun shot indicates that security must be beefed up. A lock-up area previously in the hospital no longer exists. With a secure lock-up area for psychiatric cases and suicide suspects, and a beefed up security force these type problems might be eased.

Parking--at the Phoenix Medical Center--Additional parking areas are needed as much time is lost and untold gallons of gasoline wasted in driving around the hospital in search of parking spaces. This problem could be easily solved by the procurement of unused acreage at the adjoining Phoenix Indian School so additional parking spaces could be made available.

Other problems of concern is women veterans care. Women veterans want to be examined by lady doctors when possible. If examination by a male doctor is necessary then that should only be done when a lady nurse in present.

Spinal Cord Injuries are of prime concern of the Paralized Veterans of America who recommends a 60 bed SCI long-term health care additional to the Phoenix Medical Center because:

1. Arizona is one of two non-spinal cord injured VAMC's that presently has an outpatient clinic for SCI patients.

2. The Phoenix VAMC is associated with the University of Arizona School of Medicine. There are two excellent neurological facilities in Phoenix--the Barrows Neurological Institute of St. Joseph's Hospital and the Good Samaritan Institute of Rehabilitation Medicine. The combined abilities of these three facilities would provide for competent and requisite interdisciplinary consultations. The access to the medical knowledge uniquely required for the care of the SCI person lends significant weight to the selection of Phoenix.

3. Arizona's sunbelt location is traditionally a magnet for retired people. One can easily understand that the veteran, particularly the catastrophically disabled veteran, would move to this area because of the moderate climate and the year-long accessibility to services.

The veterans population explosion does not provide data indicating the numerical increase in the spinal card disabled moving into Arizona, but a substantiated data is the unbelievable PVA membership growth of 23 percent per year since 1979.

Another factor is the nearly 1,000 spinal card disabled reportedly living in Mexico where they can receive quite reasonably, full time attendent care. With a VA SCI facility in Arizona, these SCI veterans could all receive sufficient medical longterm health care.

A dire need is necessary in the treatment of Agent Orange Victims, Atomic Veterans and, in the Protocol Examinations. These are three areas considered "a farce". Copys of procedures are to be available for the [illegible] by each VAMC and followed to allow a through exam and [illegible] over their results in a whitewash and nothing substantial.

I want the committee to understand that few complaints are made about the care a patient receives at the VAMC's once he is placed in a ward. Words of praise are heaped on the nurses for their outstanding care. Occasionally a complaint is registered about a ward doctor. This seems to be in the country-wide problem of rotation of resident doctors who experiences a communication problem with a patient and leading to a other-than-complimentary comment in the patient's medical file.

Considerable problems in the VAMC's could be relieved by the institution of evening clinics or Saturday morning clinics thus permitting the patients a shorter period of waiting time to see a doctor. Of course this would necessitate additional expenses for doctors, facilities and support staff.

Those states with expected population declines between 1980 and 1990 is Massachusettes, New York, Pennsylvania, Ohio and District of Columbia. In the following decade, declines are expected to spread to Rhode Island, Connecticut, New Jersey, Illinois, Michigan, Iowa and, South Dakota.

We do not feel that an additional allocation of funds is necessarily required, but a re-distribution of monies from those hospitals in states losing veteran population, to the Arizona VA Medical Centers would certainly aid in fullfilling the veterans health care in the Grand Canyon State.

Thank you for this opportunity to present this report on behalf of the Unified Veterans of Arizona.

Kenneth B. Pickett

Statement of

Jack E. Brady

National Junior Vice Commander

of

American Ex-Prisoners of War

Before the

House Subcommittee on Hospitals and Health Care

November 22, 1983

Mr. Chairman and Members of the Subcommittee,

I am both pleased and honored by the privilege of appearing before this subcommittee to offer the views and opinions of veterans now living in the western part of our great country. The other, larger organizations will no doubt concentrate their testimony on the concerns of the greatest number of veterans, which of course is of great interest to the American Ex-Prisoners of War as well, for we wish to help all veterans and each of us is without question a veteran of combat in one or more of our nation's wars. But we are so few in number, for which we are truly thankful, that the major interests of ex-pows may possibly be neglected. At this time, we are concerned with the implementation of PL 97-37, which some members of the Veterans' Affairs Committee Helped to make law by introducing or sponsoring.

Although some may think I am selfishly excluding the interests of other veterans, that is not my intent. Please remember that PL 97-37 is about thirty or more years overdue in our opinion, and it is already late for most of us, and too late for some. In

the past, Congress provided legislation intended to help, but by the time it had been interpreted and re-interpreted at the various levels of the Veterans Administration, it was no longer effective. This time the Congress has made its intent clear, and we hope to follow through to insure that the intent becomes a reality. To do so may require that we approach the Congress for additional legislation.

I believe it is important that I emphasize the fact that for thirty years, more or less, we former prisoners-of-war have found that the Veterans Administration at almost every level was somewhat less than sympathetic toward our condition. Fortunately, there were some exceptions, but a large number of us ex-prisoners, because of our prior experiences, depended on private physicians when and if we could afford their fees. We were told over and over, "It's all in your head", which may very well be true, but no help was forthcoming to get it out. Only with the experiences of the Vietnam War has a condition of post-traumatic stress been recognized, although it had been in the medical literature for years before that. As our conditions worsened and the burden of ever-higher medical expenses was coupled with a decreasing ability to earn income, we approached the VA for help, but did so with the well-supported suspicion that we would be refused the needed care. It is only now, two years after the Congress made a clear statement of its intent, that the Veterans Administration has succeeded in changing the attitude of some of its employees. At least, we are no longer told that we "are trying to get a free ride just because (we were) prisoners of war." Those are the words of a

former chief adjudication officer of a Regional Office at a meeting attended by about eighty ex-pows and their wives. We thank the Congress for its role in making this change possible and, in fact, requiring that the change take place.

In preparing this statement, we have relied on reports about the hospitals in Seattle, Tacoma, Roseburg, Fresno, and Albuquerque. We also have statements from some ex-prisoners as individuals. There are still some of us who do not, and say they never will, use the medical facilities made available to them by PL 97-37. The medical benefits of that law became effective on October 1, 1981. The other provisions of PL 97-37 became effective on the date it was signed, i.e., August 14, 1981.

Perhaps because so much was required of the VA, it was only in April, 1983, that a comprehensive medical history form was approved and even longer for it to be put to use. I refer to VA Form 10-0048, entitled "Former POW Medical History." Even after that length of time, the form shows some minor signs of haste in its preparation and some lack of understanding of the prison experience on the part of those who prepared it. Regardless of its minor faults, it is a vast improvement over anything in use prior to it. The form is used by examining doctors to guide them during the most comprehensive physical examination most ex-pows have ever had since their repatriation. It is in that fact that one deficiency is immediately apparent. Some examinations were performed before the form was distributed. It is possible, and even worse, most likely that none of those examinations were as thorough and complete as they should have been. It was reported that at one of the prior examinations, the doctor asked the ex-pow, "What am I supposed to

look for?" Later, at the request of the ex-pow, he was given an examination with the Form 10-0048 as the basis. The ex-pow states that he believes he received a complete examination at that time. I recommend that anyone examined before the VA Form 10-0048 was used should be recalled for another examination using that form.

One of the unfortunate features of the records kept by the Armed Forces is that not all of them indicate who was a prisoner. Where the records did show that information, there was no method to retrieve it. One result of that situation was the outreach program initiated by the VA as required by PL 97-37 to identify and locate all living ex-pows. With the help of the American Ex-Prisoners of War, all the other veterans' organizations, news releases, radio announcements, and other methods, the program was largely successful. The primary object was to notify each one of us individually of the newly liberalized provisions of the law. VA Pamphlet 27-82-1 was published in January, 1982, with that in mind. In most cases, copies were received in the mail. However, in at least one area, it is stated that no one known to the maker of the statement received it in that fashion. Most got a copy from one of the veterans' organizations.

We know that there are other ex-prisoners who are still not aware of the information contained in the pamphlet. We are occasionally told of one by the spouse or a child seeking help for the former prisoner. The VA has done a heroic job in reaching as many as they have, but I believe this effort must be continued. There are also cases of persons who refuse to acknowledge his status as an ex-prisoner of war and will not under any circum-

stances seek the help he needs and is entitled to receive. These people may require some form of psychiatric outreach program once they are identified. They may never be reached, but I believe the effort must be made on a continual basis.

With some exceptions, the medical help that is now being given is of high quality once the patient sees a doctor. If actually admitted to the hospital as a patient, there seems to be nothing but praise. That is not the case in the outpatient clinics. It is an unhappy fact that there are lay clerks intervening between the veteran and the doctors who can help him. Whatever the cause, there are a large number of complaints about the lack of clerks, the indifference of the clerks, the ignorance of the clerks, the appearance of the clerks and in some cases the truculence of the clerks. It appears that there is an overload of perhaps as much as 25%. This causes excessive waiting time for the veteran (sometimes as much as three hours or more) and harried and overworked clerks and doctors. Perhaps a larger funding for this part of the patient load is in order.

There is another segment of the hospital system which deserves high praise. From every report received in which dental care is mentioned, it is always in the best of terms. One possible reason for this lies in the fact that the Congress made clear its intent to provide dental care for ex-pows in PL 96-22 which was effective in October, 1979, and incorporated in PL 97-37. The four year period of its existence has enabled all concerned to work out any problems and it is now an accepted part of the routine.

With persistence, luck, continuous emphasis and training, and perhaps some additional legislative action, PL 97-37 will work in 1985 as well as PL 96-22 does now. I hope it will not be too late for many more of us.

Statement of

Melvin L. Routt

National Director

of

American Ex-Prisoners of War

Before the

House Subcommittee on Hospitals and Health Care

November 22, 1983

Mr. Chairman and Members of the Subcommittee:

I am thankful for the privilege of being before this panel as I believe such hearings can be a great benefit to the V.A. as well as to the veteran in obtaining good health care.

As a National Director, I travel to all the V.A.H. in California, which is made up of the 26th and 27th Medical District, and would like to pass on to you my findings. Though we finally have a good law PL97-37, we are still having trouble putting it to work in all the V.A.H. and find many different interpretations of it from one V.A.H. to the other.

Central office says one thing, but by the time it reaches the low rank and file, it's never the same.

This Medical District #27 is, at this time, trying hard to improve this under Dr. Upton of the Livermore V.A.H. who is in charge of the X-POW Programs. The 26th District is starting their program under Dr. Morris of Loma Linda Hospital.

There is a great need for additional physicians as well as administrative people to absorb the additional work load caused by passage of 97-37 and various other

programs such as Agent Orange, nuclear exposure, etc. These bills are passed by Congress with good intentions but without additional staffing, they cannot be absorbed by the existing staff if they are to be implemented as Congress intended! Medical training teams need to be established to go to the various districts to provide adequate training courses for the physicians and administrative people responsible for the various programs. This must start at the Central Office so the program would be uniform throughout.

As to the medical protocol V.A. form 10-0048, which is to be used by the doctors to fill in the lack of medical record of which the enemy did not keep, this form is to be put in the X-POW's medical record for future reference and does not mean the opening of a claim unless requested by the X-POW or the denial of one since 97-37 was passed. The V.A. Central Office has asked all X-POWs to fill out this form, however, we found the S.D. area will not give out forms unless the X-POW is opening a claim. We also found cases where the X-POW was told they were out of the forms. We also found in other cases the POW Coordinators are not listed in the hospital directory and difficult to find. In other cases, they really didn't kn w what their job was.

The Central Office has a proper format for the X-POW patient data card; the priority status and POW stamped on the face of it. However, some hospitals would not make the proper card, and in many cases, the veteran was able to get this done by going to another V.A. hospital.

Another finding which is a great waste of time and money to the V.A. as well as to the veteran, is on an exam under the new form 10-0048; starting the examination under one doctor and two or three weeks later, starting all over again under another doctor. I realize that different problems sometimes require a doctor in that field, but one should not have to start at the beginning each time, which often happens.

I would like to say our problems are not with the top people in the V.A. The break down is more often in the beginning with the very first people we see; the G.S.3s and 4s. Somewhere from the top down the line of communication is lost.

I again thank the panel and would like to state I am grateful to be an American and free. I am also grateful to one of the finest health care organizations in the world and do believe with your help, it will be able to correct these problems as the age of the World War II veteran is working against us. I thank you.

BAY AREA & WESTERN CHAPTER
paralyzed veterans of america
Chartered by United States Congress
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STATEMENT OF
EDWARD F. PITTELKOW
PRESIDENT
BAY AREA & WESTERN CHAPTER
PARALYZED VETERANS OF AMERICA
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF
THE HOUSE COMMITTEE ON VETERANS' AFFAIRS,
THE HONORABLE BOB EDGAR, CHAIRMAN
CONCERNING
INPATIENT AND OUTPATIENT HEALTH CARE
IN THE PALO ALTO VA MEDICAL CENTER
NOVEMBER 22, 1983

Mr. Chairman and members of the sub-committee, Bay Area & Western Chapter, Paralyzed Veterans of America appreciate this opportunity to present its views on the health care delivery system at the Palo Alto VA Medical Center. Bay Area & Western chapter is one of 33 member chapters of National PVA. As with all PVA members and chapters, we are veterans who have experienced spinal cord injury or dysfunction and due to that experience and dysfunction, we have considerable contact with Palo Alto VA Medical Center Health Care System and the supplemental facilities and other extended medical health care services provided by the Veterans Administration.

Bay Area & Western's statement will concentrate on two areas: The first subject we wish to address is the number of beds; and the second, will address the specific needs of spinal cord injured veterans.

I. 30 Bed Unit

The Palo Alto Spinal Cord Injury Service has a 30 bed capacity, unfortunately this leaves a serious void when compared with the fact that these 30 beds are 93% percent utilized at all times. These figures represent an average daily census of 28 patients for 30 beds with a total of 52 individual veterans hospitalized per month. This leaves us with a problem of being unable to extend medical care to the maintenance care patients, along with newly injured. This center was first designed for a 60 bed unit, however, only 30 were built! Since the Palo Alto SCI unit services northern California, the Northwest and a large number of veterans in the Mountain States this understandably causes many problems that are inherent because of this magnitude.

Because of the bed shortage, emergency admission means that SCI veterans who have examinations scheduled must be abruptly notified of cancellations and rescheduled. This can be especially frustrating for catastrophically disabled veterans who have unique travel problems that must be arranged in advance. Furthermore, the problem is aggravated when SCI veterans must plan to travel long distances for care, as is often the case in these areas.

The information from the SCI study shows a definite need for increasing the number of SCI beds at Palo Alto. As noted before there is at Palo Alto a 93% occupancy rate. We understand that the VA plans on building a new 60 bed unit at Palo Alto beginning sometime in 1986 or 1987. The Bay Area & Western Cahpter PVA, recommends that a high priority be given to this project and that the dates be pushed up.

II. Specific Needs

The specific needs of the spinal cord injured veteran at Palo Alto are as follows:

1.) Long term care - over the years PVA-Bay Area & Western Chapter has established a rapport with the administration of the hospital and the Chief of Spinal Cord Injury Services whereby we can sit down and discuss any existing problem and attempt to find a viable solution.

Nonetheless, some of the problems that are existing today and some that have been resolved tentatively, have existed for over 30 years, around the time PVA was incorporated in Illinois as a Veterans Service Organization. At that time, an SCI veteran was not expected to live for any length of time. Fortunately, with the advancement of medical technology, some of those same SCI veterans are still living today. Thus in spite of the non-existence of a major war the SCI veterans population has grown and according to the statistics that we have seen, it will continue to grow.

Therefore, we are faced with not only the young long term SCI veteran but the geriatric veteran as well.

The dilemma that was also created by the paternalistic attitude toward the SCI veteran has come back to be an albatross around the Veterans Administration neck. We are faced now with a veterans population that has aged and is in need of long term care due to the fact that their spouses have gotten older and creating additional medical problems and no longer financially or physically able to take care of themselves. In the same vein, the paternalistic attitude fostered a rehab program that was geared to institutionalization rather than mainstreaming. Subsequently, we are faced with pushing forth crash programs to accommodate existing population and to insure that we do not create any more long term care SCI veterans.

SOLUTIONS: VA involvement in the contracting for and the supervision of nursing homes; extended care units, paraplegia hostelries and domiciliaries must be considered and supported.

2.) Personnel - for years, SCIS has always lacked an adequate amount of personnel and adequate trained personnel. From our National testimony, you are aware that Physicians, RN's, and LPN's are greatly underpaid by thc VA compared to the private sector. This does not offer an incentive for these individuals to remain in the system. We must look at the salary range of our health care professionals and make them commensurate with their counterparts in the private sector in order to offer incentives to remain in the VA medical System in addition to the Educational Programs.

Moreover, the SCI patient who is exposed to more nursing assistants than he is to Physicians, RN's or LPN's is subject to receive inadequate care due to the shortage of these individuals, not only in the nursing home unity, but on SCIS itself. It is a common practice amongst these individuals once they have been recruited and trained to SCIS to seek transfers to other units within the hospital or even other services who offer higher pay for less work on an opportunity for advancement. Bay Area & Western Chapter proposes that hiring practices must be improved, recruitment techniques must be improved. The VA must offer paid scales comparable to those of private sectors. In addition to that, we must offer other gratuities for the retainment of these individuals once they have been orientated to SCIS. Taking it one step further, education opportunities and opportunities for advancement should be offered to the individual. Thus we must offer incentives such as the upgrading and the change of title to SCI Nursing Specialists, along with grade and step increases. However, this is dependent upon whether or not the Nursing Director sees fit to hire Nursing Assistants to RN's and LPN's. Surely we realize that in this low economical period, and the nature of the job, that many times you can recruit individuals who are sub-standard in education or insensitive to the needs of the individual patients. Therefore, it may be necessary to make the criteria for acceptance into SCI Specialists more rigid.

However, if the Nursing Director decides that LPN's and RN's can provide the services that the SCI veteran health care needs, for his daily activities, then they must be educated to the fact that their duties will go beyond passing medication, dressings and the like. Since we are talking about bowel and bladder care, dressing and other personal hygiene necessities that most SCI veterans need from health care providers, RN's and LPN's are reluctant to perform these duties.

Our next area of concern is the lack of the knowledge within hospitals that is multi-disciplinary hospitals, when it comes to treating an SCI veteran outside of SCIS. Far too many times, we have experienced cases where an SCI veteran goes to another service for surgery or other medical care and returns with decubitis, bladder or other infections which could have been avoided if these individuals were orientated on how to care for the SCI veteran.

To compound this, we have witnessed discriminatory attitudes toward the SCI veteran because other individuals placed emphasis on his drug and alcohol problem. Bay Area & Western Chapter admits that some drug and alcohol abuse exist and in the same vein it has questioned and suggested several times that a drug abuse and alcohol program for SCI veterans should be established. It has long been recognized that the SCI veteran drug and alcohol abuse, more often than not, are attributed to the ramifications of he/she becoming an SCI individual. In addition to his spinal cord injury, it must be recognized that those individuals who have a drug abuse or alcohol abuse problem are indeed in need of professional help in this area.

3.) Specialized equipment, medicine and supplies. The SCI patient requires specialized equipment, medicines and supplies on an on-going basis germane to his injury that are not common to the other types of disabled veterans within the medical system. The timely delivery of such items as cathethers, external cathethers and other life supporting supplies and medicine is paramount for the day to day existence of this veteran.

Too often the veteran has to wait beyond the exhaustion of those items before they have been refilled and moreover, he does not receive an adequate amount of the items to sustain him until the next authorized refill period. This can be attributed to the lack of knowledge of those medical items necessary for the sustaining of this individual outside an institution. The nurse practitioner has worked very well with the pharmacy in trying to alleviate this lack of knowledge. However, with the turnover of personnel in that area or apathy on their part, we are still experiencing these problems. I can only state that this is due to budgetary restraints imposed by the Congress .. and therefore, we must take a look at the system to make sure that all class of veterans are treated equally according to the individual needs.

In the same vein we at PVA, along with the nurse practitioner, have and will continue to encourage the SCI veterans not to abuse the system.

4.) Female Veterans. The problem of the female SCI veteran. In the past, this worthy individual was passed off to other private sector hospitals or affiliated medical facilities. However, as statistics have shown there has been a marked increase not only in the female veteran coming into the VA system but the SCI female veteran coming into

the VA system. We can expect with the increase of women enlisting in the service, an increased in leisure time, which fosters these injuries, more female veterans in our medical system. We must provide a mechanism by which we can render her adequate and equivalent care.

5.) Rehabilitation. Comprehensive rehabilitation programs have not improved one iota since the Korean War and in many areas have regressed. Physical rehabilitation has always played a stellar role in the SCI Service and as good as it is, it is not good enough. Being taught and learning daily living activities, such as: putting on your pants, combing your hair, and using a knife and fork are all well and good and are the basic rehabilitation activities; but, the SCI veteran deserves more than just the basics. Bay Area & Western Chapter PVA has learned through the years that one activity that brings all aspects of the rehabilitation processes into play is an active, well designed, disciplined athletic program. The VA games is a case in point. Participation of the veterans in the games shows clearly the interest generated by these activities; and this interest and participation will last as long as the active life of the veteran. Yet, there is no comprehensive athletic program in the Palo Alto SCI Center and very little activity by any of the inpatients at this facility.

We understand that with only a 30 bed unit at this time it's very difficult to instill a comprehensive athletic program for the inpatients that have to be discharged as soon as possible to make room for another patient. However, a program could be established for outpatients.

In conclusion, I would like to express to this body that we have experienced and will continue to experience a good working relationship with the Administration of the medical facility. And we will continue to work along with them to find the best possible solution to the problems. Bay Area & Western appreciates the time and consideration extended to it by the members of this subcommittee. Mr. Chairman, and members of the subcommittee, this concludes my statement and I will be glad to answer any questions that I can.

PREPARED STATEMENT OF EARL GUNNELS, JR., STATE COMMANDER,

DEPARTMENT OF CALIFORNIA, VETERANS OF FOREIGN WARS OF

THE UNITED STATES

.EDIPP DISTRICT NO. 27 - LIVERMORE VA MEDICAL CENTER DEFICIENCIES -

Listed below are deficiencies that have caused apprehension and concern by both staff and patients attending the Medical Center. These deficiencies are a consequence of inadequate budgeting, and probably because of a Central Office design to alter Livermore VA mission to that of a Model Extended Care Facility.

1. Deficiency in Nursing Staff. The general nursing standards for patients of illnesses such as are hospitalized at Livermore is 4.4 hours per patient per day. The current standard at Livermore is 1.7 hours per patient per day.

2. Inadequate Ambulatory Care. Inadequate space and clerical help is patiently obvious from the crowds that gather in this contained area. Four doctors saw 34,000 patients in 12 months. These figures were presented to joint committee J.A.C.

3. Inadequate Medical Attending Staff. To cover the needs of the patients attending, and also to cover their own sick leave, annual leave, holidays, etc. These figures do not represent other obligations of M.D. in Department.

4. Inadequate Technical Staff. An outstanding example in the Laboratory which cannot provide adequate 24 hour a day Lab coverage for patients who reside in such areas as the SICU, Respiratory Intensive Care and Medical Intensive Care Units which must be manned 24 hours a day.

5. Inadequate Night Professional Coverage. Many attending staff, although not capable of the broad skills in acute medical care, must be on duty as long as 36 hours in carrying our MOD duty.

6. Inadequate Diagnostic Facilities. Compared to patient load demands:

    1. Non-replacement of an angiographic equipment in the past three years.

    2. Inadequate X-ray equipment with repeated breakdowns such as tomograph.

    3. Refusal to replace electromyographic diagnostic equipment for neurological and rehabilitation services.

    4. Refusal to consider a CT Scanner now in common usage in every community hospital.

    5. Refusal to purchase dual image scanner for vascual and cardiac imaging - Ultrasound.

    6. Refusal and delay in equipping Outpatient Clinics to reasonable standards for patient examination, privacy and minor care.

EDUCATION - A budget figure of $5,000 for the travel and post-graduate education of all professional and nursing staff. This figure should be compared in contrast to the Director's fund for similar purposes.

PSYCHIATRY CLOSURE - Reduction of the surgical beds and the constant unspoken threat of closure of acute care and alterations of mission, have greatly undermined the moral of the professional staff.

In other words, with the budgeting, it is impossible for us to recruit and to maintain quality physicians and surgeons. They just will not come here with all these problems of not giving them the quality equipment they need to perform their quality care.

MEDIPP DISTRICT NO. 27 - VA HOSPITAL - FRESNO, CA.

We have a problem with the pharmacy here at the Fresno VA Hospital, MEDIPP District No. 27.

It takes approximately three hours waiting for the medication and in some cases the veterans have to come back the following day. I don't believe that the veteran should be penalized because of some incompetent people that put their time in the pharmacy.

I'm sure that this does not happen at other VA Hospitals.

* *

It has been brought to my attention that the fee basis card holders in the Northern part of the State are having difficulties in obtaining doctors to honor their fee basis card.

When I checked with the hospital at Ft. Miley, I find that the situation has been taken care of and the doctors are being paid promptly at this time.

However, we still get numerous complaints over veterans who cannot obtain doctors and doctors unwilling to use fee basis cards because of long delays in getting payments from the Veterans Administration.

MEDIPP DISTRICT NO. 26 - JERRY L. PETTIS MEMORIAL VA HOSPITAL, LOMA LINDA, CA.

Most of the problems that we are having here at Jerry L. Pettis Memorial VA Hospital in Loma Linda are as the result of the hospital not being properly funded for the number of veterans that are using the hospital. The last two years this hospital has had to curtail treatment and care to nearly all non-service connected veterans toward the end of the fiscal year. Last year prescriptions were curtailed to non-service connected veterans as early as May. These veterans were limited to one, I repeat, one fifteen-day supply of medication with no refills. Last fiscal year, the hospital was funded for 1,700 patients and ended up seeing over 160,000 patients. The year 1984, the present fiscal year, the hospital was funded for 140,000 patients and the forecast for the workload may go as high as 180,000 patients. So again, it will be necessary for the hospital here to curtail the non-service connected treatment. The VA has not taken into consideration when they planned the budget for this fiscal year or the other fiscal year.

Jerry L. Pettis Memorial VA Hospital has a great influx of patients who come to this area in the winter to become temporary residents. These patients use the VA Hospital. Many of them being non-service connected enjoyed the highest priority. The VA Regional MEDIPP District 26 has made a study of a veteran that has moved into VA here permanently. However, they failed to take into consideration the influx of temporary patients that come each winter. If the veterans residing in the area are to receive proper medical care and treatment as entitled to by our laws, then it will be necesssary that more funding and a larger budget be provided to this hospital.

Let it be pointed out by Congress that the VA has made a critical mistake when they started to classify the classification of veterans as service connected and non-service connected. A veteran who served this country fighting is just as much deserving of medical care and treatment as the unfortunate veteran who ended up being wounded or contacted a wartime illness or disease.

It has been pointed out by the VA that as veterans grow older they have more chronic disease which are non-service connected. But these veterans are being shunned aside by the VA in this local area even though VA doctors have recommended treatment for these patients and have recommended prescriptions. However, the VA Hospital here in Southern California often are out of funds and cannot fill the prescriptions at VA expense, forcing the veteran to go outside to have these prescriptions filled. Many veterans are unable to afford the price of the prescriptions which is exceedingly high in this area. Therefore, they go without treatment and end up having the ailment get to such a degree that they must continue to either go without these medications, or to such a degree that they are required hospitalization.

Let it be pointed out that a veteran is a veteran and all veterans should receive a treatment for him to cure that ailment regardless of the classification he enjoys.

We, in Southern California, are having many problems with the VA and they may be more critical than those in Northern California.

THE AMERICAN LEGION
DEPARTMENT OF CALIFORNIA
117 WAR MEMORIAL VETERANS BUILDING
SAN FRANCISCO, CA 94102-4587
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P77

STATEMENT OF HAL GOLDMAN, DEPARTMENT COMMANDER
THE AMERICAN LEGION, CALIFORNIA
BEFORE THE SUBCOMMITTEE ON
HEALTH CARE
November 22, 1983

Dear Mr. Chairman and Members of the Subcommittee:

It is an honor and a pleasure for me to have the opportunity to appear today before this distinguished Subcommittee, as the representative of more than 116,000 members of The American Legion.

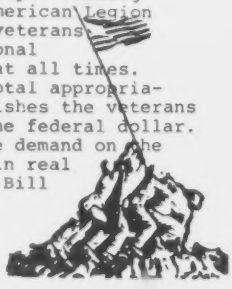
The American Legion and its Auxiliary do, in fact represent a broad cross section of the veteran population in the state of California, because of this we believe we can speak for the veterans and their needs in the state of California.

With these facts in mind we do believe we can speak authoritatively on hospital and health care rendered to the veteran population by the Department of Medicine and Surgery of the Veterans Administration.

I would now like to address the Subcommittee on some of the matters that are of direct concern to our organization at the present time. More specifically this hearing is intended to review inpatient and outpatient Veterans Administration health care in the VA's western medical region as represented in the Northern California area.

BENEFIT ADJUSTMENTS

The most important feature of any presentation we make to this Subcommittee inevitably must be on the subject of proper funding for veterans programs. It is the position of The American Legion that when national priorities are set, funding for veterans programs should rightfully rank second only to national defense, which must be the first national priority at all times. Currently VA appropriations approximate 3% of the total appropriations for the federal government. This fact establishes the veterans programs are not consuming an increasing share of the federal dollar. Members of The American Legion are well aware of the demand on the federal dollar. The cost of the veterans programs in real dollars is decreasing with the phase down of the GI Bill



program and if there are no future wars, the cost will continue to decline as the veteran population decreases in size.

VETERANS MEDICAL CARE

The National organization of The American Legion visits and surveys 60 VA Medical Centers each year, we know the dire need for additional personnel. The VA cannot practice high quality, state of the art medicine without sufficient staff personnel. We do want to make a point that with all the good things that the VA Department of Medicine and Surgery are doing with current funding the VA health care system still has many problems that must be addressed. Some of these problems are natural to a system of such vast size and scope, and some relate to various other factors many of which can be remedied. To this end, the Legion urges this Subcommittee to deal with these problems.

In California we have some 3 million of the nations veterans. The aging generation of the World War II veteran concerns The American Legion. These veterans are coming into the stage of life when they will increasingly be subjected to the catastrophic illnesses that are associated with advancing years. The cost of private medical care I am sure this Subcommittee is well aware of. This will cause more and more of the aging veteran to turn to the Veterans Administration which most of them have not been doing during the years since they returned from service.

The need for Long Term Nursing Care beds in the state of California is critical. The need for additional outpatient clinics in various areas of the state such as the far northern section of California which has no VA facilities. The closest being to the San Francisco area and in some cases some 100 to 200 miles distant.

All of us want the best possible medical care in our twilight years. We in The American Legion feel that this is an entitlement that the veteran has earned by virtue of his willingness to serve this country in a time of need.

The Korean veteran is also of great concern to The American Legion. He and she are aging and again with the high cost of private medical care many are turning to the VA for that care.

The Vietnam era veteran has suffered many problems since their discharge from military service. Whether the VA or specifically the Department of Medicine and Surgery have been responsive to the needs of the Vietnam era veteran has been questioned. In the judgment of The American Legion we feel that the VA's record in this area is

spotty in this regard. There continues to be some VA physicians who either cannot or will not recognize Post-traumatic Stress Disorder as a pathological condition which can be identified and treated. We do not understand why the VA cannot get its doctors to understand and deal with the disease entity. Failure to do so has alienated many veterans, and is one of the main reasons why it was necessary to establish the VA Outreach Centers - a development for which Congress deserves much credit. These centers have been of great help but of more help would be proper medical and psychiatric care for the individual who suffers from Post-Traumatic Stress.

Agent Orange of which you are all well aware has been the topic of much discussion. The American Legion has urged the Congress and the Veterans Administration to resolve this issue as quickly as possible and in a just and unbiased study. We are in hopes that the results of this study will shortly come to light. It is long overdue.

WOMEN VETERANS

There is an increasing number of women veterans, the Congress and now hopefully the Veterans Administration in recent years is paying more attention to that. The American Legion has accepted woman veterans into membership from the time of its founding in 1919. We have many thousands of female veterans who are members of our organization. These woman veterans are entitled to the full range of benefits including specifically health care. For many years VA Medical Centers were oriented to the male patient, we feel that the female veteran is entitled to all phases of medical care. We encounter instances where insensitivity is demonstrated or there is a misunderstanding between the woman veteran and VA staff. It is the intention of The American Legion to bring these specific cases directly to the attention of the Director of the medical facility involved. If the problem cannot be resolved at the local level you have the assurance of The American Legion that it will be brought to the attention of the Chief Medical Director in Washington, D.C. and if necessary to the Administrator of Veterans Affairs.

MEDICAL FACILITY CONSTRUCTION

The American Legion Department of California is aware that the state of California has more medical facilities than any other state in the nation. However we hasten to point out that California has more veterans than any other state in the nation by far. Additional beds in California is desperately needed more specifically to utilize

all the available beds in our medical facilities in California would certainly temporarily adjust the problem. We feel that inadequate funding at the Washington level has curtailed and even closed many beds in the facilities here in California. We would also like to point out that in many medical facilities proper and adequate parking is always a problem. Veterans seeking medical services at most of our VA facilities are usually ill or have disabilities that effect ambulation. In many instances they are required to walk blocks to reach the front door of some of these medical facilities.

BURIAL ALLOWANCE

The American Legion is well aware that this Subcommittee is primarily interested in VA Medical Centers and Health Care. However we wish to point out that the Omnibus Budget and Reconciliation Act of 1981 discontinued the burial allowance to most of our veterans. The American Legion did not agree with this action. We believe it was a mistake. We feel that this benefit should be restored at the earliest possible date. This particular reduction in a benefit has adversely effected many thousands of veterans. The credibility of the Congress and the Veterans Administration in the eyes of those veterans has been effected. To restore that credibility we feel that the burial allowance should be restored at the earliest possible date.

CONCLUSION

Mr. Chairman and Members of the Subcommittee I have presented here certain matters that are of current importance to the American Legion. What The American Legion wants for the veteran is what is fair and just. Working together we believe the goals of fairness and justice can be achieved. As stated earlier in this presentation the Veterans Administration is not a perfect agency. Nothing that size can be. We do feel improvements can be made. We thank you for allowing us to present the views of The American Legion Department of California before this Subcommittee on hospitals and health care.

Thank you.

PREPARED STATEMENT OF PAUL O. BATTISTI, ADMINISTRATOR, VETERANS HOME OF CALIFORNIA, REPRESENTING THE CALIFORNIA DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman, members of the Sub-committee on Hospitals and Health Care:

I am Paul O. Battisti, Administrator, Veterans Home of California, representing the California Department of Veterans Affairs.

The Department of Veterans Affairs is responsible for programs in veterans services, farm and home loans, and long-term residential and health care.

The Veterans Home of California is a 1550 bed facility located at Yountville in the Napa Valley. The Home cares for an average of about 1400 veterans in five levels of care from acute to independent living. The average age of the members of this community is 74 years. Our population includes veterans from World War I through the Vietnam conflict. We accommodate women veterans (134) and a unique program for couples, including non-veteran spouses. Ours is primarily a geriatric facility. We appreciate your invitation to testify at this hearing because, as one of 47 such facilities nation-wide, we represent a significant resource in meeting the long-term care of our nation's veterans. Further, as stated in GAO Report HRD-82-7 on October 22, 1981, the state homes are "a cost effective alternative to providing care in VA facilities". This is not to say that we can or should be an alternative to VA care, but rather that the state facilities offer a cost effective partnership with the VA in helping to meet the long-range needs for total health care of the nation's veterans.

As partners, the VA and state homes should seek ways for more effective joint planning, cost sharing, cooperative programs for

education and research, and for sharing of talent and expertise.

The Veterans Home of California will celebrate its Centennial in 1984. It has enjoyed a distinguished record of service to veterans in good times and bad. Today, we are on the threshhold of a renaisance which will modernize, replace or renovate all of our buildings to meet current state and federal fire, life/safety and environmental codes. We are relying on the VA's 65% grants program to complement the legislature's endorsement of this $40 Million Master Plan. In the last five years, the state has demonstrated its committment to quality care at the Veterans Home with a 25% increase in staffing and a 100% increase in total budget.

We urge the Veterans Affairs Committee of the House of Representatives, and its sub-committee on Hospitals and Health Care to view the state home programs as a valued and competent partner in delivering health care to veterans. The VA could well profit from a positive, supportive, and cooperative relationship with the state homes with a resulting beneficial effect on the veterans we are dedicated to serve.

STATEMENT OF

DANIEL E. COONEY

REGIONAL DIRECTOR

WESTERN REGION

VETERANS ADMINISTRATION

DEPARTMENT OF MEDICINE AND SURGERY

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

NOVEMBER 22, 1983

SAN FRANCISCO, CALIFORNIA

Mr. Chairman and Members of the Subcommittee:

On behalf of the Veterans Administration and the Department of Medicine and Surgery, I would like to welcome you to San Francisco, the home of the Western Region field office. The primary mission of every Veterans Administration Medical Center and Outpatient Clinic is to provide the highest quality health care to our nation's veterans. We in the Western Region are committed to this mission. We recognize, however, the additional imperative of offering quality services in a cost effective manner.

The Western Region encompasses an enormous area, spanning from Southwestern Texas north to Alaska and west to the Philippines. More specifically, the Region includes Western Texas, two counties in Oklahoma, New Mexico, Arizona, California, oregon, Washington, Alaska, western Nevada, western Idaho, northwestern Montana, Hawaii, the Trust Territories of the Pacific Basin, American Samoa and the Philippines. Within this area are twenty-five medical centers and domiciliaries, three independent outpatient clinics and three outpatient clinics that are organizationally aligned under the DVB Regional Offices in Alaska, Hawaii and Manila. Nearly all are affiliated with schools of medicine and all provide exemplary medical care. Fiscal Year 1983 employment levels exceeded 29,640 FTEE.

The Region is for the most part a sparsely populated geographic area, with major population concentrations in several locations, including the Albuquerque-El Paso corridor, Phoenix-Tucson corridor, Los Angeles-San Diego metropolitan area, San Francisco Bay area, and coastal Pacific Northwest. The total veteran population for the Region was 5,256,200 in 1980 and is projected to be 5,012,780 in the year 1990. The number of veterans age 65 and over is also projected to grow to 1,276,310 in the year 1990, a 220% increase from population of 581,950 in 1980. Approximately 216,600 female veterans currently reside in

the Western Region, representing approximately 4.1% of the total population and 2.6% of the discharges in FY83.

The aging veteran population presents a significant challenge to us, and is being addressed in a number of ways. The Western Region has appointed the Agency's first Regional Coordinator for Aging, Paul A. L. Haber, M.D. Dr. Haber is probably known to many of you through contact within his previous reole as the Assistant Chief of Medical Director for Geriatrics and Extended Care. Dr. Haber's primary responsibility will be the development of a Regional Plan for Aging. Additional subplans will include developing a system for caring for the visually impaired elderly veterans in the WesternRegion as well as working to enhance the application of technology for Aging.

Throughout the Region, plans are proceeding to address the bed care needs of the aging veteran, including proposals to construct several new nursing homes as well as an additional domiciliary. The MEDIPP process allows us to undergo the necessary metamorphosis to bring about an appropriate mixture of hospital beds to meet the demands of the population we serve. We are excited about the progress that is being made in the Western Region to meet this challenge.

The Western Region currently has 11,423 authorized hospital beds, 1,654 domiciliary beds, and 1,191 nursing home beds. The MEDIPP plans for 1990 now in for review and approval projects an authorized hospital bed capacity of 11,571 beds, domiciliary beds totaling 1,553 and 3,026 beds authorized for nursing home care. In 1983 the Region was assigned a community nursing home census of 1,684. The year 1990 proposes a census level of 6,129. Fiscal Year 1983 showed a combined average daily census of 8,825, patients treated totalling 206,290 and 3,482,977 outpatient visits. By 1990, our projections indicate an average daily census of 9,835 (11.4% growth), 191,700 patients treated, and 4,389,8127 outpatient visits (26% growth). Occupancy rates in 1983 averaged 78% with projections in 1990 indicating 85%. The Western Region performed 18,744 Agent Orange examinations in 1983. Growth continues in the VA Outreach Centers with 96,099 visits recorded in 1983, a 14.6% increase over the 82,033 visits recorded for 1982.

Any number of additional statistics are available for us to review, but I would like to defer further elaboration on them until you present your specific questions. I believe that the problems and issues that we deal with throughout the Western Region can be further illustrated by focusing in on one of its Medical Districts, District 27.

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Medical District 27 includes Central and Northern California, most of Nevada, Hawaii, Trust Territory of the Pacific, American Samoa and the Philippines. Within this area are six medical centers (Fresno, Livermore, Martinez, Palo Alto, Reno and San Francisco), two satellite outpatient clinics (Oakland and Sacramento), and two independent outpatient clinics under the aegis of DVB Regional Offices (Honolulu and Manila). The medical facilities are affiliated with five medical schools: (1) Stanford University, (2) the University of Hawaii, (3) the University of Nevada-Reno, (4) the University of California-Davis, and (5) the University of California-San Francisco.

Medical District 27, much like the rest of the Western Region, encompasses a large, and for the most part, sparsely populated geographic area. Four of the medical centers are located in the San Francisco Bay Area within 60 miles of each other, where about one-half of the district's veteran population is concentrated. The other two medical centers are located about 170 miles (Fresno) and over 200 miles (Reno) from this major population center. While major interstate highways, public transportation and air transportation services exist within the district, access to care is often limited by travel distances, geographic terrain and seasonal weather conditions. The total veteran population of the district

was 1,451,700 in 1980 and is projected to by 1,161,010 in 2000. The number of veterans age 65 and over is projected to increase almost threefold by the year 2000 (from 150,990 in 1980 to 436,200 in 2000). Approximately 65,000 female veterans currently reside in Medical District 27 and were responsibvle for 997 discharges in FY 82 and approximately 1,050 in FY 83. As in the other districts within the Western Region, the accessibility of health care services within District 27 is an ongoing issue for our veteran population, especially those living in Northern California. The development of health care delivery mechanisms to effectively and efficiently serve the veterans in our outlying areas will continue to be a major planning and operational issue in the District.

The District 27 Strategic Plan (MEDIPP) contains many proposals that provide for a continuum of care to meet the challenges of increased care for the aging veteran population. Included in the Plan are proposals for additional extended care services at Fresno, Livermore, Martinez, Reno, and San Francisco; inpatient and outpatient rehabilitation capabilities at all facilities; nursing home additons at Palo Alto, Reno, and Livermore; new nursing homes at Honolulu, Martinez, and San Francisco; domiciliary bed capability at Palo Alto; and further development of alternatives to institutional care (such as hospice, respite and adult day health care program) at all

facilities. This District maintains a close working relationship with the California State Veterans Home in Yountville, which provided care for the 643 hospital/domicilary patients and 642 nursing home care patients in FY 83.

Medical District 27 currently has 2761 authorized hospital beds and 390 VA nursing home beds. Through the District's planning process there is projected a need for 2868 authorized hospital beds and 930 VA nursing home beds. The number of full time employment equivalent (FTEE) employees includes 1292.1 FTEE registered nurses and 413.2 FTEE physicians. Medical school affiliations increase physician staffing levels by 369.6 FTEE hourse officer positions.

The medical centers in the Western Region continue to be recognized among the most progressive medical centers in the entire Veterans Administration. Medical District 27 is among the leaders in this regard. Capabilities within the District include a Blind Rehabilitation Center, a Rehabilitation Engineering Research and Development Center, a Regional Telephonic Pacemaker Surveillance Program, a Spinal Cord Injury Center, and a Geriatric Research Educational and Clinical Center. The medical centers in District 27 are recognized nationally in clinical and administrative applications for ADP including such areas as Supply-procurement; Pharmacy-patient profiles, inventory

management, and prescription dispensing; Medical Administration-patient registry and profiles. In addition, the District has pioneered in developing and implementing its own methodology in allocation of medical care monies among its facilities.

Workload and productivity measures for the Western Region are among the highest in the country. District 27 provides an excellent example why. Overall, the hospitals maintain an occupancy rate ranging from 72% to 81%. The total number of patients treated for FY 83 was 39,927 plus 5,777 one-day dialysis visits. The outlying clinics in Honolulu and Manila arranged fore an additional 2463 patients to be treated at federal and non-federal facilities. 851,872 outpatient visits were accomplished during FY 83. Noteworthy is that the outpatient visits exceeded planned levels by over 16 percent. The Medical District is current in the processing of Agent Orane examinations which totalled 2,338 exams in FY 83 and has appointed a physician coordinator at each medical center for the POW health assessment program. The Medical District continues to support the efforts of the outreach teams at eight Vet Centers. Workload continues to grow in the program with 27,861 visits recorded in FY 82 and 34,644 visits in FY 83.

The FY 83 medical care target allowance for Medical Distreict 27 was just over $279 million and in FY 84 it is $306 million. In addition, the six medical centers have over $15 million in funded research encompassing geriatric research, mental and behavioral research, and many basic and clinical research areas.

This fiscal year the medical centers will accomplish projects totaling $7.2 milliion in the nonrecurring engineering maintenance and repair program. In addition, $1.8 million in Jobs Bill funding has been obligated in FY 83 to support another 14 M&R projects in the District.

The Western Region has been at the forefront for the sharing of our medical resources. The role of Mewdical District 27 has been most significant. It is our belief that the implementation of Public Law 97-174 which authorized VA/DOD sharing will enhance sharing opportunities because of the incentives dealing with reimbursement availability at the local level. VA/DOD agreements predating the implementation of Public Law 97-174 exist between VAMC San Francisco and Letterman Army Medical Center, VAMC Livermore and the Oak Knoll Naval Regional Medical Center, Honolulu Outpatient Clinic and Tripler Army Medical Center, VCAMC Martinez and the Oak Knoll Naval Regional Medical Center. Expansion of sharing agreements are being pursued with local non-VA health care

agreements are being pursued with local non-VA health care facilities as well as federal health care facilities.

The Western Region track record both in delivering patient care services and participating in new programs and initriatives has been sustained through conscientious management. Continued management flexibility will insure future successes in meeting the challenges of an eroding resource base, deepened by recruitment and retention difficulties, changing economic conditions, expanded eligibility mandated by legisltation, not necessarily accompanied by resource adjustments and facility aging and structural obsolescence.

Improved accuracy in the allocation of recurring funding, however, will address only one set of issues. Nonrecurring renovation and construction projects are also critical to the future of the VA's health care delivery system. In order to prepare for the changes in demand envisioned by the MEDIPP process and to improve the overall physical environment of the facilities to allow for more efficient provision of medical care, a number of large construction projects will be accomplished in the next few years. Within the Western Region, there are currently in progress $395 million in major construction projects. In the Region's five-year facility plan, there is projected another $115.4 million in major construction.

Finally, while MEDIPP has given us the tools to predict future demand based on demographic data, we have few tools to predict future demand influenced by economic trends. We believe that many of our new consumers are unemployed, and now uninsured, veterans who previously received their health care in the private sector. State reductions in Medicaid funding and pending changes in the Medicare reimbursement structure may be encouraging both public and private sector providers to instruct individuals to utilize their veteran benefits. We are continuing to study more rigorously the extent of consumer influx; however, the full impact of the economy's shifts will remain difficult to assess.

In conclusion, I wish to express my appreciation to the Subcommittee for this opportunity to discuss the Veterans Administration health care system in the Western Region. We look to the future confident that we will be able to continue to deliver high quality services to our veteran. As managers, we view the challenges as pathways to innovation and improved performance. We are proud of our medical centers, our dedicated staffs, and our volunteers and we welcome you to San Francisco. This concludes my statement, Mr. Chairman. My colleagues and I will be pleased to respond to any questions that you or members of the Subcommittee may have.

STATEMENT OF

MARVIN E. O'REAR

MEDICAL CENTER DIRECTOR

VETERANS ADMINISTRATION MEDICAL CENTER

LIVERMORE, CALIFORNIA

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

NOVEMBER 22, 1983

SAN FRANCISCO, CALIFORNIA

Mr. Chairman and Members of the Subcommittee:

I am pleased to have this opportunity to appear before your Subcommittee and I am personally delighted, Mr. Chairman, that you and your colleagues have gone throughout the country to see first hand the Agency needs for providing care to the veterans of this country. May I reiterate for the record publicly on behalf of my entire staff, how pleased we were you took the time to visit our Medical Center which as you heard yesterday, spoke volumes to the morale of the entire staff.

Since Mr. Cooney and his staff have compiled a comprehensive resume' of each of the medical centers in this district, I will not duplicate that information in my presentation.

Anticipating your practice at previous hearings of inquiring as to the three things of which I am most proud, I would respond as follows: First and foremost must be the unswerving dedication and commitment of our people in spite of the adversities of tight budgets, staffing shortages, space deficiencies in both quantity and functionality, equipment funding which precludes the timely purchase of needed equipment and inadequate funds to meet staff education needs; second, inseparable from the first is the high

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quality of compassionate care provided to our patients which is continuously confirmed by the patients themselves and their families; third, the continued (the long term) dedication and support from our over 350 number of volunteers to the Livermore Medical Center.

With regard to the three most severe problems handicapping the optimal provision of health care would be: (1) the increasing decremental funding and the decreasing managerial flexibility imposed by categorical restrictions on operational use of funds, e.g., restrictions on the use of personal services dollars caused by the dollar floor, limitation on other analysis accounts such as equipment (.19) and NR M&R (.23); (2) reduced funding for equipment, travel and education; (3) Congressional authorization of additional benefits without commensurate funding, e.g., beneficiary travel, expansion of the permanent duty reimbursement for moving expenses (maximum weight increasing from 11,000 to 18,000 lbs., real estate reimbursement, etc.).

Mr. Chairman, that concludes my statement, and I would be pleased to respond to any questions the Committee may have.

FEB 03 1984

(02C)

Honorable Norman D. Shumway
House of Representatives
Washington, D.C. 20515

Dear Mr. Shumway:

On December 15, 1983, Congressman John Paul Hammerschmidt submitted questions on your behalf regarding the San Francisco field hearing of the Subcommittee on Hospitals and Health Care held on November 22, 1983.

A copy of the enclosed answers has been forwarded to Congressman Hammerschmidt. I appreciate this opportunity to provide further information for the record.

Sincerely yours,

JOHN P. MURPHY
General Counsel

Enclosure

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSE

HON. NORMAN D. SHUMWAY TO VETERANS' ADMINISTRATION

Question 1. In light of the fact that some of my constituents, as well as others from Northern California, must travel many hours to the closest VA hospital, are there any plans to open a VA facility in one of the more northern regions in California?

Answer. Not at this time.

Question 2. Presently, what are the allowances for California residents to cross over state lines and use the VA hospital in Reno, Nevada? Are there ever instances where a California resident would have to travel further than the one located in Reno?

Answer. Veterans are not prohibited in any way from crossing state lines to make use of VA health care facilities. In nearly all cases, primary service areas of responsibility for VA health care facilities are based on geography and historical patterns of seeking care. California residents may seek their health care in Reno if they find that particular facility to be the most appropriate to meeting their particular needs. Reimbursement for travel incurred by the veteran is designed to compensate him or her for travel to the nearest appropriate VA facility based on distances and availability of services.

Question 3. Why, against the wishes of the hospital itself, are the psychiatric and surgical units being eliminated in Livermore? What allowances are being made for those who presently rely on these services?

Answer. The determination of bed services and program levels to be provided at a VA medical center are made through a comprehensive planning process known as Medical District Initiated Program Planning (MEDIPP). Through a comprehensive sequence of reviews by planning review boards, the Directors Council, the District and Regional Directors, a plan is compiled which then undergoes final examination by the program directors in VA Central Office. Final review and approval by the Chief Medical Director and Administrator are required before the plan is initiated. In the case of the Livermore VA Medical Center, as well as others in similar circumstances, the services no longer being provided will be accommodated through use of other VA health care facilities within the area. However, if an individual re-

ceiving care in the Livermore facility needs emergency treatment which that facility is not equipped to provide, he or she may be transferred to a local hospital for the needed treatment.

Question 4. What is the best way for veterans to find out what services are available to them: Has the idea of a toll-free hotline, set up for information purposes ever been discussed?

Answer. There are a number of sources available to the veteran to learn about services that are available to him. The State of California, as well as many others, has a sophisticated and effective county service officers network established which can be most useful to a veteran seeking information. Many state schools and universities also provide veterans benefits counselors or referral processes. VA medical centers offer veterans assistance counselors within their confines to render information. The many veteran service organizations are available to assist the veteran as well. We have considered a toll-free hotline, however, we feel that the aforementioned items are a more effective use of resources.

Statement of the Honorable Norman D. Shumway

Mr. Chairman, I appreciate this opportunity to include my remarks in the record for this the sixth and final hearing on the quantity and quality of health care provided for our Nation's veterans. In light of the fact that within the next few years the large majority of our World War II veterans will be turning sixty-five, the need for such an extensive nationwide hearing schedule is compelling. The able subcommittee chairman, Mr. Edgar, and the ranking minority leader, Mr. Hammerschmidt, are to be commended for their insight and leadership. I would also like to welcome the various members of the subcommittee to the State of California and thank the expert panel of witnesses assembled here today for their testimony on this urgent matter.

The portion of California which I am privileged to represent encompasses the entire northeastern section. Within this area are thousands of miles of beautiful mountainous and rural settings where many older Americans, many of whom are World War II veterans, have chosen to spend their retirement years. It is precisely at this time of their lives when both their in-patient and out-patient veteran health benefits become exceedingly important to them. Of the six existing veterans hospitals available for service in this region, district 27, as many as five are used by my veteran constituents.

Mr. Chairman, I have received a great deal of input from my constituents in the form of praise for the health care services offered by the VA. However, my major concern with these facilities is their accessibility. I would estimate that the average travel time to a VA hospital for veterans residing in California's 14th Congressional District is between two to three hours. Those in the northern most regions have even further to travel. Certainly this puts a tremendous strain, both physically and economically, on a large number of northern California's veteran population. It is my desire to see outreach to these more removed northern areas—particularly in the form of out-patient care.

I am particularly pleased, Mr. Chairman, to learn of the two major construction projects now under way at the Palo Alto and San Francisco facilities. I strongly believe that every consideration should be given to our deserving veterans and their medical needs and these sorts of additions will benefit our region greatly. Thank you again Mr. Chairman and with your permission I have submitted several questions on the subject matter for consideration by today's expert witnesses.

Hon. John Paul Hammerschmidt to Veterans' Administration

Question 1. Sometimes under the rules you terminate non-service-connected outpatient treatment—including the filling of prescriptions—of patients who have been previously hospitalized or previously provided such care. Can you explain such termination to an elderly veteran?

Answer. Yes. The Veterans' Administration has recognized the need to know and understand the system of care on the part of our veteran patients. Accordingly in 1980, positions organizationally titled "Health Benefits Advisor" were established at each medical center. These individuals' primary responsibility is to be conversant with federal regulations and be capable of explaining these regulations in simple language. This personal touch in the admissions area has been so successful that there has been a significant decrease in the number of complaints concerning a lack of knowledge about how the system works. It should be understood that before any

veteran's care is terminated, his or her case is reviewed by a physician, to assure that such termination is appropriate to the veteran's health status. Exceptions which allow for continued care to non-service-connected veterans have been made when a thorough review of the patient's ability to obtain such care through other mechanisms indicates that no alternative sources of such care are available.

Question 2. I know that my old friend, Dr. Paul Haber, now works in your Region and is responsible for planning your Aging Program. Please tell us about that program.

Answer. Briefly, the Aging Program includes several initiatives. The first includes Health Care Technology, the development of diagnostic/therapeutic devices and procedures, drugs, and prosthetics. There are two types of technology involved in this program, one referred to as low technology, the development and testing of simple devices which can enhance the quality of life of an older person. The second level is high technology which can also be referred to as robotics. The development and use of robotics will have significant impact throughout the field of health care for both institutionalized patients and those patients at home.

Another initiative being developed is a network of facilities based upon visually impaired service teams, which currently exist at some 73 hospitals. The principle is to triage visually impaired individuals and refer them to those facilities where the appropriate levels of care can be provided.

A third initiative is ambulatory care for the elderly. The intent of this program is to develop a system which can provide both outpatient diagnosis and therapy, specifically for the elderly.

Question 3. Are your hospitals receiving complaints about Agent Orange or atomic radiation examinations not being complete, or not being explained properly to the veterans who have them?

Answer. No. Initially, there were numerous complaints concerning the timeliness and accessibility of examinations. In the latter part of 1978, each medical center designated as a focal point for this program, an environmental health physician. The responsibility of this person is to continually monitor the timeliness and thoroughness of examinations. The environmental health physician, through various nationwide conference calls, printed circulars, and educational conferences keeps abreast of developments in this field (both clinical and administrative) and transmits this information to medical center personnel involved with these programs.

As a result of the collective actions of the medical centers and the environmental health physicians, examinations are now being completed in a timely and complete manner.

Question 4. The VA is now going to have the authority to determine qualifications and set rates of pay for licensed physical therapists, respiratory therapists, and licensed practical and vocational nurses. The office of personnel now has this authority. How is this going to help in this area of the country in terms of recruitment and retention of these kinds of employees?

Answer. The Western Region, specifically California, has since the late 1970's been handicapped by the inability to respond rapidly to escalating professional/allied health rates of pay. As a result, recruitment and retention of these numerous positions was significantly affected. The ability to determine qualifications and establish rates of pay will greatly increase the flexibility with which medical centers, not only in California, but in the rest of this Region, can respond to the dynamics of the everchanging health care field.

Question 5. The volunteer program of the VA greatly contributes to the success of its medical activity. Please give us a status report as to this District about your volunteers.

Answer. During fiscal year 1983, Medical District 27 enjoyed the services of 3,002 volunteers contributing a total of 466,773 hours. In FTEE equivalence, this comes to 224 positions.

Question 6. In your testimony you mention that a number of research projects are funded for the District. Please tell us something about the type of research that is taking place and tell us how the research program relates to the actual giving of treatment to our veteran patients.

Answer. Clinical and nonclinical investigators cover a broad spectrum of health care issues in Medical District 27's research programs. These include biomedical research, health care services delivery, rehabilitation research and development, and geriatric research. For example, the thrust of our medical research program is the creation of new medical knowledge and support of the VA's health care system, which will improve our understanding, diagnosis, and treatment of diseases that are prevalent among our patients.

Several programs are of particular note. These are a Rehabilitation Research and Development Center, the Geriatric Research Education and Clinical Center, and the Schizophrenia Biological Research Center all located at VAMC Palo Alto. The primary focus of all three is to improve the quality of life and to allow more functionally independent daily living for the physically and mentally disabled or infirmed. In addition, as already noted, the Geriatic Center is responsible for improving our understanding and treatment of disease that are prevalent among elderly patients.

The research conducted at VA medical centers applies not only to the VA, but to medical systems around the world. The flow of information resulting from our research program frequently appears in journals not only in the United States, but around the world. This information is utilized for the benefit of our veteran patients as well as the benefit of the population as a whole.

Question 7. Will you tell us what additional specific plans you have for increased sharing with the military under Public Law 97-174, the VA-Department of Defense Sharing Act?

Answer. Within Medical District 27, there are a number of proposals for VA-DOD sharing being reviewed. For example, VAMC Fresno has begun preliminary discussions with the Commanding Officer at Lemoore Naval Hospital in regards to sharing of nuclear medicine. VAMC Livermore already maintains an agreement with the Oak Knoll Naval Regional Medical Center for antiographic, radiology, and CT scans. VAMC Martinez already has a number of informal sharing agreements and has begun exploring the possibility of formalizing these. Included are radiotherapy (exchange of information, equipment, and educational services) with the David Grant Air Force Medical Center and the Oak Knoll Naval Regional Medical Center; and the use of library facilities with Grant, Letterman, the Naval Language School in Monterey, and the Naval Regional Medical Center; and with emergency products loans for pharmacy supplies with David Grant Medical Center. VAMC Reno has also begun discussions with Fallon Naval Air Station to provide medical care to active duty personnel.

In Medical District 28 another innovative agreement has been made between the VA Outpatient Clinic Anchorage, Alaska and Elmendorf Air Force Base Hospital. Under the terms of this agreement a physician has been hired by the VA and is stationed at the Air Base rendering care to both the VA outpatients and Air Force patients. Also, a pharmacist and a pharmacy technician have been hired by the VA and will be used as part of the Air Force hospital staff. In exchange for these staff services, Elmendorf Air Force Hospital will provide mail-out pharmacy prescription services to all VA beneficiaries in the State of Alaska and outpatient treatment services to veterans with access to the Anchorage area.

Question 8. What is your waiting time for processing admission to the hospitals in this District? Also what is the waiting time at the pharmacies for prescriptions? What is the time element on mailed prescriptions?

Answer. The average processing time for admission to a hospital in Medical District 27 is approximately two hours. It should be kept in mind that this is from the time the patient walks through the door until the time he/she is actually on the wards. The average waiting time for a patient prescription is 40 minutes and for mailed prescriptions, there is a turnaround period of approximately two days.

Question 9. I understand that the Denver VA Hospital has experimented with a laundry technique concerning doing laundry with cold water as opposed to hot water and that it proved that the technique was efficient and that it saved a lot of money. Doing laundry in VA Hospitals is big business. Has this experiment been exported to this medical Region?

Answer. The decision has been made to convert all VA laundries to low temperature water usage. Studies conducted at VA Medical Center, Denver, Colorado, and Drexel University in Pennsylvania showed comparable bacteriological effects using low and high temperature washing when appropriate chlorine and drying procedures were used. Surveys of nosocomial infection rates in laundries using low temperature laundering procedures indicated no adverse impact on nosocomial infections during the survey period. As a result of these findings, laundries in VA Regions 1 and 2 will be converted to low temperature water use beginning in February 1984. Following this, laundries in Regions 3 and 6 will be converted within a year.

Question 10. What is the status of compensation and pension physical examinations? Are you current throughout the Region?

Answer. Compensation and Pension examinations are current. Our standards require that 65 percent of the total number of examinations must be completed within 30 days of receipt; 90 percent within 60 days and 98 percent in less than six months. The Western Region's average processing time is 35.5 days. One hundred percent of the examinations received are completed in less than 60 days.

Question 11. In your testimony, you mention the California State Veterans' Home at Yountville. Is that facility usually operating at capacity?

Answer. The California State Veterans Home at Yountville is authorized 749 domiciliary and 740 nursing home care beds. During fiscal year 1983, Yountville's average daily census was 645 domiciliary and 632 nursing home care patients. The occupancy rate for fiscal year 1983 was 86 percent. This rate does not reflect that approximately 200 beds are temporarily closed due to various construction projects. With this in mind, the occupancy rate is close to 100 percent. The Veterans Home at Yountville has traditionally run a high census and it is anticipated that it will continue to run at or near capacity in the future.

This situation was recently recognized by the California Assembly Select Committee on Veterans' Affairs which endorsed a resolution calling upon the state to conduct a study to determine the feasibility of establishing a second veterans home in Southern California.

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